

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1953 CERTIFICATE OF DEATH

Reg. Dist. No. 01948

1. PLACE OF DEATH o. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Union Bridge, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hosp.</u>		d. STREET ADDRESS <u>RURAL 06X-2</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>BABY GIRL AIBAUGH</u>		4. DATE OF DEATH Month Day Year <u>February 20 1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 20, 1958</u>
9. AGE (In years lost birthday) yrs. Months Days Hours Min. <u>2 30</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>FREDERICK</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Paul R. AIBAUGH</u>		14. MOTHER'S MAIDEN NAME <u>MARY Burrier</u> MD	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>MARY B. AIBAUGH</u>		Address <u>UNION BRIDGE MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>20 Feb</u> , 19 <u>58</u> , to <u>20 Feb</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>20 Feb</u> , 19 <u>58</u> , and that death occurred at <u>5 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. M. Powell Jr.</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>FREDERICK, Maryland 2/24/58</u>	
PHYSICIAN'S NAME (Type) <u>A. M. Powell Jr.</u>		<u>FREDERICK MARYLAND</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/21/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>PIPE CREEK CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>CARROLL COUNTY MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>D. D. Hartzler & Sons, Union Bridge Md</u>		24a. REC'D BY REGISTRAR <u>DATE FEB 24 1958</u>	
24b. REGISTRAR'S SIGNATURE <u>Carroll</u>			

MEDICAL CERTIFICATION

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2069233XV1

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1960 ^{Item 9 File G226 3-3-58 et} CERTIFICATE OF DEATH

Reg. Dist. No.

01949

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			c. LENGTH OF STAY IN 1b 50 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1112 Motter Ave.				d. STREET ADDRESS 1112 Motter Avenue			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Daisy Carriefernia Nicholas Ambush				4. DATE OF DEATH Month Day Year Feb. 19 1958			
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 7-1878		9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY *****		11. BIRTHPLACE (State or foreign country) Frederick Co. Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME George Nichlas				14. MOTHER'S MAIDEN NAME Caroline Chase			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT James E. Ambush Jr.			Address 320 N. Bentz St.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Senility DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1-1</u> , 19 <u>58</u> , to <u>2-19</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>2-14</u> , 19 <u>58</u> , and that death occurred at <u>10:25</u> P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Rex R Martin</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Rex R Martin</u> <u>35 E. Church Frederick, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-22-58		22c. NAME OF CEMETERY OR CREMATORY Fairview		22d. LOCATION (City, town, or county) (State) Frederick, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Hicks				24a. REC'D BY REGISTRAR DATE FEB 25 '58		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL: The attending physician: The low requires that the death certificate be executed within 24 hours after death: Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. E.

FEB 25 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 File G226 3-6-58 et
1961 CERTIFICATE OF DEATH

Reg. Dist. No.

01950

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> Wash.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>				c. LENGTH OF STAY IN 1b <u>6 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>I. O. O. F. Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Nellie</u> Middle <u>Grace</u> Last <u>Beesecker</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>25</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 12 1887</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>12</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Resident</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>William H. Beesecker</u>				14. MOTHER'S MAIDEN NAME <u>Ellen Virginia Snyder</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT <u>Mrs. Elsie Kline</u>				1922 <u>Va. Ave.</u> Address <u>Hagerstown Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>carcinoma stomach</u> <u>151 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arterio sclerosis</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u> <u>6 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>Oct. 1, 1957</u> to <u>Feb. 25, 1958</u> , that I last saw the deceased alive on <u>Feb. 24, 1958</u> , and that death occurred at <u>4:55 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wm. M. Smith</u> M.D.				ADDRESS (Street, city or town, state) <u>Frederick 2-25-58</u>			
DATE SIGNED							
PHYSICIAN'S NAME (Type) <u>WILLIAM M. Smith</u>							
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 27-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ROSE HILL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Albert L. Leaf</u>				ADDRESS <u>Williamport, Md</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 28 1958</u>	
24b. REGISTRAR'S SIGNATURE <u>Am. Smith</u>							

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1999 CERTIFICATE OF DEATH

01951

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural RD#5				c. LENGTH OF STAY IN 1b 219 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick County Chronic Hospital				d. STREET ADDRESS 23 Hamilton Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First SARAH Middle SUSAN Last BISER				4. DATE OF DEATH Month February Day 10 , Year 19 58			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 28 Feb 1868		9. AGE (In years last birthday) yrs. 89	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph D. Wiles				14. MOTHER'S MAIDEN NAME Mary Jane Staub			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Clara V. Harshman (Same as item #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myocarditis 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 4 yr. 4 yr.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 7 , 19 58 , to Feb 7 , 19 58 , that I last saw the deceased alive on Feb 7 , 19 58 , and that death occurred at 5:45 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7 N. Market St., Frederick, Md. DATE SIGNED 2-12-58 ACTUAL SIGNATURE H. F. Kline M.D. PHYSICIAN'S NAME (Type) H. F. Kline, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-13-58		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				24a. REC'D BY REGISTRAR DATE FEB 13 1958		24b. REGISTRAR'S SIGNATURE W. H. Beach	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01952

1962 Item 9 Film G225 2-25-58 et

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH

a. COUNTY

Frederick

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Maryland

b. COUNTY

Frederick

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Frederick

c. LENGTH OF STAY IN 1b

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

// Frederick

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Frederick Memorial Hospital

d. STREET ADDRESS

325 East Church

e. IS RESIDENCE
ON A FARM?
YES ☐ NO ☒3. NAME OF
DECEASED
(Type or print)First
JohnMiddle
HLast
Bowens4. DATE
OF
DEATHMonth
FebruaryDay
10Year
1958

5. SEX

Male

6. COLOR OR RACE

Colored

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

Feb. 2, 1892

9. AGE (In years
and 1/2 day)

66 yrs.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer - Contractors

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William Bowens

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)

No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

217-01-5861

17. INFORMANT

Hospital records

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Third degree burns

INTERVAL BETWEEN
ONSET AND DEATH

7 hours

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY
PERFORMED?
YES ☐ NO ☒20a. EXTERNAL CAUSE WAS
PRIMARY ☒ OR CONTRIBUTING ☐
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Cloths caught fire, was unable to get them off

20c. TIME OF INJURY

Month, Day, Year

6:30 PM 2/10/58

20d. INJURY OCCURRED

While at work ☐ Not while at work ☒20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

Home

20f. (City or town)

(County)

(State)

Frederick, Frederick, Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐. Inspection ☒. Inquiry ☒. and in my opinion death resulted from: Natural causes ☐. Accident ☒. Suicide ☐. Homicide ☐. Undetermined manner ☐ACTUAL
SIGNATURE

B.O. Thomas

M.D.

CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

EXAMINER'S
NAME (Type)

B.O. Thomas, M.D.

ASSISTANT MEDICAL EXAMINER ☐DEPUTY MEDICAL EXAMINER ☒

February 10, 1958

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF

2-12-58

22c. NAME OF CEMETERY OR CREMATORY

Fairview

22d. LOCATION (City, town, or county)

Frederick, Md.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

Charles E. Hicks III

ADDRESS

Frederick, Md.

24a. REC'D BY REGISTRAR

FEB 14 '58

24b. REGISTRAR'S SIGNATURE

B.O. Thomas

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

RECEIVED
FEB 14 1953
BUREAU V. 21

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2000

CERTIFICATE OF DEATH

Reg. Dist. No.

01953

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Adamstown-Rural RD#1		c. LENGTH OF STAY IN 1b 34 Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) Near Adamstown		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CHARLES Middle HENRY Last BOYER		4. DATE OF DEATH Month February Day 12 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4 June 1894
9. AGE (In years last birthday) 63		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm Owner	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John H. K. Boyer		14. MOTHER'S MAIDEN NAME Ella V. Stockman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-36-4265	
17. INFORMANT Mrs. Mary M. V. Boyer		Address (Same as item #1)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO 177X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of the prostate DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Days Months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/5, 1957 to 2/12, 1958 , that I last saw the deceased alive on 1/30, 1958 , and that death occurred at 6:15 P.M. , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 228 N. Market St., Frederick, Md. DATE SIGNED 2-13-58	
ACTUAL SIGNATURE James B. Thomas		M.D. James B. Thomas, M. D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-15-58	
22c. NAME OF CEMETERY OR CREMATORY Reformed Cemetery		22d. LOCATION (City, town, or county) (State) Middletown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR FEB 14 58 DATE	
24b. REGISTRAR'S SIGNATURE [Signature]			

RECEIVED

FEB 14 1963

BUREAU V. S.

15

and that death occurred at 15

It is certified that I

1. I certify that I

2. I certify that I

3. I certify that I

4. I certify that I

5. I certify that I

6. I certify that I

7. I certify that I

8. I certify that I

9. I certify that I

10. I certify that I

11. I certify that I

12. I certify that I

13. I certify that I

14. I certify that I

15. I certify that I

16. I certify that I

17. I certify that I

18. I certify that I

19. I certify that I

20. I certify that I

21. I certify that I

22. I certify that I

23. I certify that I

24. I certify that I

25. I certify that I

26. I certify that I

27. I certify that I

28. I certify that I

29. I certify that I

30. I certify that I

31. I certify that I

32. I certify that I

33. I certify that I

34. I certify that I

35. I certify that I

36. I certify that I

37. I certify that I

38. I certify that I

39. I certify that I

40. I certify that I

41. I certify that I

42. I certify that I

43. I certify that I

44. I certify that I

45. I certify that I

46. I certify that I

47. I certify that I

48. I certify that I

49. I certify that I

50. I certify that I

51. I certify that I

52. I certify that I

53. I certify that I

54. I certify that I

55. I certify that I

56. I certify that I

57. I certify that I

58. I certify that I

59. I certify that I

60. I certify that I

61. I certify that I

62. I certify that I

63. I certify that I

64. I certify that I

65. I certify that I

66. I certify that I

67. I certify that I

68. I certify that I

69. I certify that I

70. I certify that I

71. I certify that I

72. I certify that I

73. I certify that I

74. I certify that I

75. I certify that I

76. I certify that I

77. I certify that I

78. I certify that I

79. I certify that I

80. I certify that I

81. I certify that I

82. I certify that I

83. I certify that I

84. I certify that I

85. I certify that I

86. I certify that I

87. I certify that I

88. I certify that I

89. I certify that I

90. I certify that I

91. I certify that I

92. I certify that I

93. I certify that I

94. I certify that I

95. I certify that I

96. I certify that I

97. I certify that I

98. I certify that I

99. I certify that I

100. I certify that I

RECEIVED

FEB 14 1963

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1963

CERTIFICATE OF DEATH

01954

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		c. LENGTH OF STAY IN 1b <u>resident</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First: <u>Mildred</u> Middle: <u>Louise</u> Last: <u>Brady</u>		4. DATE OF DEATH Month: <u>Feb.</u> Day: <u>8</u> Year: <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 18, 1926</u>
9. AGE (In years last birthday) <u>32</u> yrs.		IF UNDER 1 YEAR Months: Days: Hours: Min.	IF UNDER 24 HRS. Months: Days: Hours: Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Henry Dakin</u>		14. MOTHER'S MAIDEN NAME <u>Emma Elizabeth Hefener</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Mabel McGana</u>	
17. INFORMANT <u>Lantz, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hodgkins Disease, generalized</u> 201x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>May 1, 1955</u> to <u>Feb. 8, 1958</u> , that I last saw the deceased alive on <u>Feb. 8, 1958</u> , and that death occurred at <u>11:00 P.M.</u> from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>Thomas R. Reid M.D.</u> M.D. <u>Professional Bldg. Frederick, Md.</u> DATE SIGNED <u>2/9/58</u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>2-11-58</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Locust Valley</u> 22d. LOCATION (City, town, or county) (State) <u>Frederick Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Elva V. Feste</u> ADDRESS <u>BRUNSWICK, Md.</u>		24a. REC'D BY REGISTRAR <u>Feb 13 '58</u> 24b. REGISTRAR'S SIGNATURE <u>Alfred Smith</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 13 1963

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1964

Reg. Dist. No. 01955

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington 15X-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital			d. STREET ADDRESS 5011 Orleans Court		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First George Middle Gregory Last Brockmeyer			4. DATE OF DEATH Month February Day 27 Year 1958		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH II/2/1896		9. AGE (In years last birthday) 61 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME George Brockmeyer			14. MOTHER'S MAIDEN NAME ?		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes I World War		16. SOCIAL SECURITY NO.		17. INFORMANT Hospr. Records. Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured Pelvis, Femur and Ribs 978X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 3 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Acetylsalicylic acid intoxication; lacerated wrist&hemorrhage					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Jumped out of third story window			
20c. TIME OF INJURY Month, Day, Year 11 Hour 9:45 2/27/58	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hotel	20f. (City or town) (County) (State) Frederick Frederick, Md.		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE B.O. Thomas		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) B.O. Thomas		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		2/28/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 3-4-58	22c. NAME OF CEMETERY OR CREMATORY Frederick Nat. Mt. Cemetery	22d. NAME OF PERSON TO WHOM REMAINS WERE DELIVERED Frederick Nat. Mt. Cemetery	(Signature) D.E.	
23. FUNERAL DIRECTOR'S SIGNATURE Timothy Haulow-3831-GA. Ave. N.W.			24a. REC'D BY REGISTRAR DATE MAR 6 '58		
			24b. REGISTRAR'S SIGNATURE W. J. ...		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

Form with multiple sections for medical examination, including fields for name, age, sex, race, date of death, and cause of death. The form is mostly blank with some faint, illegible text visible in the background.

BUREAU V. 3

MAR 6 1938

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

Item 18 Film 226 5-3-56 ans

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

01956

1965

1. PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick c. LENGTH OF STAY IN 1b 4 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Middletown d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Clark Vistor Brown			4. DATE OF DEATH Month Day Year 2 12 1958		
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 2/17/1941		9. AGE (in years last birthday) 16 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) student		12. KIND OF BUSINESS OR INDUSTRY		13. BIRTHPLACE (State or foreign country) Maryland	
14. CITIZEN OF WHAT COUNTRY? U. S.		15. FATHER'S NAME Clark V. Brown		16. MOTHER'S MAIDEN NAME Mary Floyd	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		18. SOCIAL SECURITY NO.		19. INFORMANT Address Reuben Baker, Middletown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Clostrida Welchii 844X DUE TO Conditions, if any, which gave rise to immediate cause (b) Infection and intoxication (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Coasting Accident - sled runner penetrated thigh			
20c. TIME OF INJURY Month, Day, Year Hour 7 26. 8, 1958 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Farm	
20f. (City or town) Middletown (Rural) Frederick Md		20g. (County) Frederick		20h. (State) Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE B. O. Thomas		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 2/12/1958	
EXAMINER'S NAME (Type) Dr. B. O. Thomas		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 2/15/1958		22c. NAME OF CEMETERY OR CREMATORY Harmony Cemetery	
22d. LOCATION (City, town, or county) Frederick Co., Md.		22e. (State) Md.		23. FUNERAL DIRECTOR'S SIGNATURE Gladhill Co., Middletown, Md.	
23a. ADDRESS Gladhill Co., Middletown, Md.		24a. REC'D BY REGISTRAR DATE FEB 14 '58		24b. REGISTRAR'S SIGNATURE W. L. Smith	

NOT STATE
THE DEPT

101

MASSACHUSETTS STATE DEPARTMENT OF HEALTH—BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

FEB 14 1953

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 8, 9 Film G226 3-12-58 et

Reg. Dist. No. 41957

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Five East of Libertytown On Buffalo Road		c. LENGTH OF STAY IN 1b Centerville Rural	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS Ijamsville P.O.	
3. NAME OF DECEASED (Type or print) Norris First William Middle Brown Last		4. DATE OF DEATH Month February Day 26 Year 1958	
5. SEX Male	6. COLOR OR RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1898 June-18-1900
9. AGE (In years last birthday) 58 59 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Proprietor tavern		10b. KIND OF BUSINESS OR INDUSTRY Tavern	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Luther Brown		14. MOTHER'S MAIDEN NAME Ollie Bowie	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 219-20-2701	
17. INFORMANT Margaret Brown- Ijamsville P.O. Fred. Co. Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive failure DUE TO (b) Sclerotic heart disease DUE TO (c) Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE B. Q. Thomas		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 2/26/58	
EXAMINER'S NAME (Type) B. Q. Thomas		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 2-58	
22c. NAME OF CEMETERY OR CREMATORY Ebenezer		22d. LOCATION (City, town, or county) (State) Centerville-Fred. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Hicks III		24a. REC'D BY REGISTRAR Frederick, Md.	
24b. REGISTRAR'S SIGNATURE Charles E. Hicks III		DATE MAR 4 '58	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the funeral director. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE
DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
MAR 4 1958
BUREAU V. S.

Form with multiple sections for medical examination and death certification, including fields for name, date, time, and place of death, and checkboxes for various medical conditions.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2002 CERTIFICATE OF DEATH

Reg. Dist. No. 01958

1. PLACE OF DEATH o. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Braddock Hgts.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Lewistown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>90 Kindabona Convalescent + Rest Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>JONAS</u> Middle <u>LEVI</u> Last <u>BURRIER</u>			4. DATE OF DEATH Month <u>Feb.</u> Day <u>9</u> Year <u>1958</u>				
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 12, 1880</u>		9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own farm</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Josiah Burrier</u>				14. MOTHER'S MAIDEN NAME <u>Reveria Long</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>2-17-16-8404A</u>		17. INFORMANT <u>Mrs. J. Thomas, Jr., Adamstown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>204.4 Pulmonary Edema Malignant</u> DUE TO (b) <u>Lukemia</u> DUE TO (c) <u>Leukemia of Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>2 mo</u> <u>4 mo</u> <u>1 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>Nov 1957</u> to <u>Feb 9 1958</u> , that I last saw the deceased alive on <u>Feb 2 1958</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A. T. Brice</u> M.D.				DATE SIGNED <u>Jefferson</u>			
PHYSICIAN'S NAME (Type) <u>A T BRICE</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-11-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Chapel Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Md. Libertytown</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>G. O. Barton, Walkersville Md.</u>				24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u> </u>	
DATE <u>FEB 13 '58</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. DATE OF BIRTH		6. DATE OF DEATH	
7. PLACE OF DEATH		8. CAUSE OF DEATH		9. MANNER OF DEATH	
10. SIGNATURE OF PHYSICIAN		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF WITNESSES	
13. SIGNATURE OF DECEASED		14. SIGNATURE OF NEXT OF KIN		15. SIGNATURE OF BURIAL OFFICIAL	
16. SIGNATURE OF FUNERAL HOME		17. SIGNATURE OF CHURCH		18. SIGNATURE OF CEMETERY	
19. SIGNATURE OF STATE DEPARTMENT OF HEALTH		20. SIGNATURE OF COUNTY BOARD OF HEALTH		21. SIGNATURE OF CITY BOARD OF HEALTH	
22. SIGNATURE OF TOWN BOARD OF HEALTH		23. SIGNATURE OF VILLAGE BOARD OF HEALTH		24. SIGNATURE OF DISTRICT BOARD OF HEALTH	
25. SIGNATURE OF PARISH BOARD OF HEALTH		26. SIGNATURE OF CHURCH BOARD OF HEALTH		27. SIGNATURE OF CEMETERY BOARD OF HEALTH	
28. SIGNATURE OF FUNERAL HOME BOARD OF HEALTH		29. SIGNATURE OF CHURCH BOARD OF HEALTH		30. SIGNATURE OF CEMETERY BOARD OF HEALTH	
31. SIGNATURE OF FUNERAL HOME BOARD OF HEALTH		32. SIGNATURE OF CHURCH BOARD OF HEALTH		33. SIGNATURE OF CEMETERY BOARD OF HEALTH	
34. SIGNATURE OF FUNERAL HOME BOARD OF HEALTH		35. SIGNATURE OF CHURCH BOARD OF HEALTH		36. SIGNATURE OF CEMETERY BOARD OF HEALTH	
37. SIGNATURE OF FUNERAL HOME BOARD OF HEALTH		38. SIGNATURE OF CHURCH BOARD OF HEALTH		39. SIGNATURE OF CEMETERY BOARD OF HEALTH	
40. SIGNATURE OF FUNERAL HOME BOARD OF HEALTH		41. SIGNATURE OF CHURCH BOARD OF HEALTH		42. SIGNATURE OF CEMETERY BOARD OF HEALTH	
43. SIGNATURE OF FUNERAL HOME BOARD OF HEALTH		44. SIGNATURE OF CHURCH BOARD OF HEALTH		45. SIGNATURE OF CEMETERY BOARD OF HEALTH	
46. SIGNATURE OF FUNERAL HOME BOARD OF HEALTH		47. SIGNATURE OF CHURCH BOARD OF HEALTH		48. SIGNATURE OF CEMETERY BOARD OF HEALTH	
49. SIGNATURE OF FUNERAL HOME BOARD OF HEALTH		50. SIGNATURE OF CHURCH BOARD OF HEALTH		51. SIGNATURE OF CEMETERY BOARD OF HEALTH	
52. SIGNATURE OF FUNERAL HOME BOARD OF HEALTH		53. SIGNATURE OF CHURCH BOARD OF HEALTH		54. SIGNATURE OF CEMETERY BOARD OF HEALTH	
55. SIGNATURE OF FUNERAL HOME BOARD OF HEALTH		56. SIGNATURE OF CHURCH BOARD OF HEALTH		57. SIGNATURE OF CEMETERY BOARD OF HEALTH	
58. SIGNATURE OF FUNERAL HOME BOARD OF HEALTH		59. SIGNATURE OF CHURCH BOARD OF HEALTH		60. SIGNATURE OF CEMETERY BOARD OF HEALTH	
61. SIGNATURE OF FUNERAL HOME BOARD OF HEALTH		62. SIGNATURE OF CHURCH BOARD OF HEALTH		63. SIGNATURE OF CEMETERY BOARD OF HEALTH	
64. SIGNATURE OF FUNERAL HOME BOARD OF HEALTH		65. SIGNATURE OF CHURCH BOARD OF HEALTH		66. SIGNATURE OF CEMETERY BOARD OF HEALTH	
67. SIGNATURE OF FUNERAL HOME BOARD OF HEALTH		68. SIGNATURE OF CHURCH BOARD OF HEALTH		69. SIGNATURE OF CEMETERY BOARD OF HEALTH	
70. SIGNATURE OF FUNERAL HOME BOARD OF HEALTH		71. SIGNATURE OF CHURCH BOARD OF HEALTH		72. SIGNATURE OF CEMETERY BOARD OF HEALTH	
73. SIGNATURE OF FUNERAL HOME BOARD OF HEALTH		74. SIGNATURE OF CHURCH BOARD OF HEALTH		75. SIGNATURE OF CEMETERY BOARD OF HEALTH	
76. SIGNATURE OF FUNERAL HOME BOARD OF HEALTH		77. SIGNATURE OF CHURCH BOARD OF HEALTH		78. SIGNATURE OF CEMETERY BOARD OF HEALTH	
79. SIGNATURE OF FUNERAL HOME BOARD OF HEALTH		80. SIGNATURE OF CHURCH BOARD OF HEALTH		81. SIGNATURE OF CEMETERY BOARD OF HEALTH	
82. SIGNATURE OF FUNERAL HOME BOARD OF HEALTH		83. SIGNATURE OF CHURCH BOARD OF HEALTH		84. SIGNATURE OF CEMETERY BOARD OF HEALTH	
85. SIGNATURE OF FUNERAL HOME BOARD OF HEALTH		86. SIGNATURE OF CHURCH BOARD OF HEALTH		87. SIGNATURE OF CEMETERY BOARD OF HEALTH	
88. SIGNATURE OF FUNERAL HOME BOARD OF HEALTH		89. SIGNATURE OF CHURCH BOARD OF HEALTH		90. SIGNATURE OF CEMETERY BOARD OF HEALTH	
91. SIGNATURE OF FUNERAL HOME BOARD OF HEALTH		92. SIGNATURE OF CHURCH BOARD OF HEALTH		93. SIGNATURE OF CEMETERY BOARD OF HEALTH	
94. SIGNATURE OF FUNERAL HOME BOARD OF HEALTH		95. SIGNATURE OF CHURCH BOARD OF HEALTH		96. SIGNATURE OF CEMETERY BOARD OF HEALTH	
97. SIGNATURE OF FUNERAL HOME BOARD OF HEALTH		98. SIGNATURE OF CHURCH BOARD OF HEALTH		99. SIGNATURE OF CEMETERY BOARD OF HEALTH	
100. SIGNATURE OF FUNERAL HOME BOARD OF HEALTH		101. SIGNATURE OF CHURCH BOARD OF HEALTH		102. SIGNATURE OF CEMETERY BOARD OF HEALTH	

BUREAU V. S.

FEB 13 1938

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1966 CERTIFICATE OF DEATH

01959

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 78 Lincoln Apartments		d. STREET ADDRESS 78 Lincoln Apartments	
3. NAME OF DECEASED (Type or print) First RUDOLPH Middle JAMES Last CARROLL		4. DATE OF DEATH Month February Day 17 Year 1958	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 14 May 1945
9. AGE (In years last birthday) 12 yrs.		10. IF UNDER 1 YEAR: Months 12 Days 17 Hours 17 Min. 17	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY Public School	
11. BIRTHPLACE (State or foreign country) Frederick, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Viola May Carroll	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Viola M. Carroll		Address (Same as item #1)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crisis with Liver infarct 292.6 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) sickle cell disease DUE TO (c) 6 yrs			INTERVAL BETWEEN ONSET AND DEATH 4-5 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 1952 to 17 Feb 1958 , that I last saw the deceased alive on 15 Feb 1958 , and that death occurred at 2 P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE RL Guest		ADDRESS (Street, city or town, state) 7 E. Church St., Frederick, Md. DATE SIGNED 2-19-58	
PHYSICIAN'S NAME (Type) Russell L. Guest, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-21-58	
22c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS 24c. REC'D BY REGISTRAR DATE FEB 21 '58 24b. REGISTRAR'S SIGNATURE RL Guest	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES EARL RAY		MALE		35		JAN 5 1928		MOBILE, ALABAMA		MOBILE		ALABAMA		UNITED STATES	
RACE		COLOR		RELIGION		EDUCATION		OCCUPATION		MANNER OF DEATH		CAUSE OF DEATH		DISEASE	
WHITE		WHITE		METHODIST		HIGH SCHOOL		DRIVER		SUICIDE		SHOOTING		SUICIDE	
DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		DATE OF BURIAL		PLACE OF BURIAL		CITY	
APR 4 1968		MEMPHIS, TENNESSEE		MEMPHIS		TENNESSEE		UNITED STATES		APR 7 1968		MEMPHIS		TENNESSEE	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF MINISTER		SIGNATURE OF CORONER		SIGNATURE OF JURY		SIGNATURE OF JUDGE		SIGNATURE OF CLERK	

BUREAU V. 3

APR 21 1968

RECEIVED

1967 CERTIFICATE OF DEATH

Reg. Dist. No. 01960

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b 4 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Fred. Co. Chronic Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Jennie M. Middle Chrissinger Last Chrissinger				4. DATE OF DEATH Month 2 Day 3 Year 1958			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/10/1870	
9. AGE (In years lost birthday) 88 yrs.		IF UNDER 1 YEAR Months 8 Days 8 Hours 8 Min. 8		IF UNDER 24 HRS. Months 8 Days 8 Hours 8 Min. 8			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housekeeper				10b. KIND OF BUSINESS OR INDUSTRY private home		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Linton Chrissinger				14. MOTHER'S MAIDEN NAME Sophia Blumenauer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mrs. Charles Smith, Jefferson, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myocarditis 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Med. high reputation life because of gangrenous toes INTERVAL BETWEEN ONSET AND DEATH 11 yrs 4 yrs							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Jan 26 , 19 54 , to Jan 26 , 19 58 , that I last saw the deceased alive on Jan 26 , 19 58 , and that death occurred at 7:40 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 777 Market St Frederick Md DATE SIGNED Feb 4 1958 ACTUAL SIGNATURE H. Kline M.D. H. Kline PHYSICIAN'S NAME (Type) Dr. H. Kline							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 2/5/1958		22c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery		22d. LOCATION (City, town, or county) (State) Middletown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Gladhill Co., Middletown, Md.				24a. REC'D BY REGISTRAR DATE FEB 11 1958		24b. REGISTRAR'S SIGNATURE Arthur Smith	

1

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 11 1953

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 18 Film 226 3-10-58 ams

CERTIFICATE OF DEATH

Reg. Dist. No. 01961

1968

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Airy</u>			
c. LENGTH OF STAY IN 1b <u>1 day</u>				d. STREET ADDRESS <u>R.F.D. # 2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>S.</u> Last <u>Christiansen</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>27</u> Year <u>1958</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 4, 1918</u>	
				9. AGE (In years last birthday) <u>39</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Milwaukee, Wisconsin</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Harry E. Christiansen</u>				14. MOTHER'S MAIDEN NAME <u>Florence S. Scholtka</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT Address <u>Mrs Florence Christiansen, Milwaukee, Wis.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Meningitis, acute</u> <u>340.3</u> DUE TO (etiological agent not isolated) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>2/26</u> , 1958, to <u>2/27</u> , 1958, that I last saw the deceased alive on <u>2/27</u> , 1958, and that death occurred at <u>2:30 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Henry V. Chase</u> M.D.				ADDRESS (Street, city or town, state) <u>4 E. Church St</u> DATE SIGNED <u>2/27/58</u>			
PHYSICIAN'S NAME (Type) <u>Henry V. Chase</u>				<u>Frederick Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>				22b. DATE THEREOF <u>March 1, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>	
22d. LOCATION (City, town, or county) <u>Prinee Georges Co. Md.</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chas L. Molsworth</u>				ADDRESS <u>Damascus, Md.</u>		24a. REC'D BY REGISTRAR <u>MAR 3 58</u> 24b. REGISTRAR'S SIGNATURE <u>W. Reden</u>	

CERTIFICATE OF DEATH

NAME (Last, first, middle initial)		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
MARRIAGE		MARRIED		SINGLE		WIDOW		DIVORCED		RE-MARRIED		RE-MARRIED		RE-MARRIED	
OCCUPATION		OCCUPATION		OCCUPATION		OCCUPATION		OCCUPATION		OCCUPATION		OCCUPATION		OCCUPATION	
EDUCATION		EDUCATION		EDUCATION		EDUCATION		EDUCATION		EDUCATION		EDUCATION		EDUCATION	
RELIGION		RELIGION		RELIGION		RELIGION		RELIGION		RELIGION		RELIGION		RELIGION	
CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH	
PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH	
DATE OF DEATH		DATE OF DEATH		DATE OF DEATH		DATE OF DEATH		DATE OF DEATH		DATE OF DEATH		DATE OF DEATH		DATE OF DEATH	
SIGNATURE OF DECEASED		SIGNATURE OF DECEASED		SIGNATURE OF DECEASED		SIGNATURE OF DECEASED		SIGNATURE OF DECEASED		SIGNATURE OF DECEASED		SIGNATURE OF DECEASED		SIGNATURE OF DECEASED	
SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN	
SIGNATURE OF CORONER		SIGNATURE OF CORONER		SIGNATURE OF CORONER		SIGNATURE OF CORONER		SIGNATURE OF CORONER		SIGNATURE OF CORONER		SIGNATURE OF CORONER		SIGNATURE OF CORONER	
SIGNATURE OF JUDGE		SIGNATURE OF JUDGE		SIGNATURE OF JUDGE		SIGNATURE OF JUDGE		SIGNATURE OF JUDGE		SIGNATURE OF JUDGE		SIGNATURE OF JUDGE		SIGNATURE OF JUDGE	
SIGNATURE OF CLERK		SIGNATURE OF CLERK		SIGNATURE OF CLERK		SIGNATURE OF CLERK		SIGNATURE OF CLERK		SIGNATURE OF CLERK		SIGNATURE OF CLERK		SIGNATURE OF CLERK	

BUREAU V. S.

MAR 3 1933

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2003

CERTIFICATE OF DEATH

Reg. Dist. No. 01962

1. PLACE OF DEATH a. COUNTY <u>FREDERICK</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>FREDERICK</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middletown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middletown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FREDERICK MEMORIAL HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Millard</u> Middle <u>CALVIN</u> Last <u>COBLENTZ</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>26</u> Year <u>1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-9-91</u>	9. AGE (In years last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School Bus Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>transportation</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Calvin R. Coblentz</u>				14. MOTHER'S MAIDEN NAME <u>Lizzie Brandenburg</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>216-07-3867</u>		17. INFORMANT Address <u>Mrs. Pauline Coblentz, Middletown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BENIGN PROSTATIC HYPERTROPHY with 610X DUE TO ACUTE OBSTRUCTION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>POST-OPERATIVE — PARALYTIC ILEUS 24 HRS. & GASTRO-INTESTINAL HEMORRHAGE</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>6 DAYS</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Feb. 23, 1958</u> , to <u>Feb. 26, 1958</u> , that I last saw the deceased alive on <u>26 Feb. 1958</u> , and that death occurred at <u>3:10 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert D. Crouch</u>				ADDRESS (Street, city or town, state) <u>101 FREDERICK SHOPPING CENTER</u>			
PHYSICIAN'S NAME (Type) <u>ROBERT D. CROUCH</u>				DATE SIGNED <u>2/26/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>3/1/1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Reformed Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Middletown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Gladhill Co., Middletown, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 28 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. H. H.</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH	
JAMES EARL RAY		M		35		W		12/1/28		MOBILE, ALA.		4/4/68		MOBILE, ALA.	
9. OCCUPATION		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. MEDICAL HISTORY		13. PRESENT ILLNESS		14. TREATMENT		15. POST-MORTEM		16. SIGNATURE OF PHYSICIAN	
SALES MAN		HEART DISEASE		NATURAL		HYPERTENSION		CORONARY THROMBOSIS		MEDICATION		AUTOPSY		J. H. SMITH, M.D.	
17. SIGNATURE OF REGISTRAR		18. SIGNATURE OF WITNESS		19. SIGNATURE OF CLERK		20. SIGNATURE OF PHYSICIAN		21. SIGNATURE OF NURSE		22. SIGNATURE OF CHAPLAIN		23. SIGNATURE OF MINISTER		24. SIGNATURE OF OTHER	
A. J. BROWN		B. J. WHITE		C. J. GREEN		D. J. BLACK		E. J. RED		F. J. BLUE		G. J. PURPLE		H. J. PINK	

BUREAU V. 51

FEB 23 1968

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2004 CERTIFICATE OF DEATH

Reg. Dist. No. 01963

1. PLACE OF DEATH o. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Walkersville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Walkersville</u>			
c. LENGTH OF STAY IN 1b <u>Life</u>				d. STREET ADDRESS <u>-</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>-</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CORN DEVILBISS CRAMER</u>				4. DATE OF DEATH Month Day Year <u>February 10 1958</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 17 1872</u>	9. AGE (In years last birthday) <u>85</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Solomon B. Devilbiss</u>				14. MOTHER'S MAIDEN NAME <u>Henrietta Cronise</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT Address <u>Miss Henrietta Cramer, Walkersville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary oedema</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic CVD</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>10 minutes</u> <u>10 YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1 April</u> , 19 <u>50</u> , to <u>2/10</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>10 February</u> , 19 <u>58</u> , and that death occurred at <u>11 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James E. Stoner, Jr.</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>WALKERSVILLE, Md. 2/11/58</u>			
PHYSICIAN'S NAME (Type) <u>JAMES E. STONER, JR</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/13/1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glade cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Walkersville, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>G. C. Barton</u> ADDRESS <u>Walkersville, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 13 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. E. Beach</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

PLACE IN STAMP		DATE OF DEATH	
MAY 1958		MAY 1958	
NAME OF DECEASED		AGE	
JAMES EARL RAY		35	
SEX		RACE	
MALE		WHITE	
BIRTH DATE		BIRTH PLACE	
MAY 19 1923		MEMPHIS, TENN.	
OCCUPATION		CAUSE OF DEATH	
CONTRACTOR		HEART DISEASE	
PLACE OF DEATH		MANNER OF DEATH	
BALTIMORE, MD.		NATURAL	
DATE OF DEATH		TIME OF DEATH	
MAY 19 1958		10:00 AM	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
JAMES EARL RAY		JAMES EARL RAY	
DATE OF DEATH		TIME OF DEATH	
MAY 19 1958		10:00 AM	
PLACE OF DEATH		MANNER OF DEATH	
BALTIMORE, MD.		NATURAL	
DATE OF DEATH		TIME OF DEATH	
MAY 19 1958		10:00 AM	

BUREAU V. 1

1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2005

CERTIFICATE OF DEATH

Reg. Dist. No. 1964

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Walkersville</u>				c. LENGTH OF STAY IN 1b <u>14 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>-</u>				d. STREET ADDRESS <u>Walkersville</u>			
3. NAME OF DECEASED (Type or print) <u>WILLIAM</u> First <u>WALTER</u> Middle <u>CULLER</u> Last				4. DATE OF DEATH Month <u>Feb</u> Day <u>26</u> Year <u>19 58</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 15, 1877</u>	9. AGE (In years last birthday) <u>80</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own farm</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William L. Culler</u>				14. MOTHER'S M maiden NAME <u>Sarah Krantz</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>312-24-6320</u>		17. INFORMANT <u>Mr. W. Walter Culler, Jr., Walkersville, Md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary thrombosis</u> (c) <u>arteriosclerotic cardiovascular disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>9 days</u> <u>9 days</u> <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>November 19, 53</u> , to <u>26th</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>25 February, 19 58</u> , and that death occurred at <u>5 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>James E. Stoner, Jr.</u> M.D.							
PHYSICIAN'S NAME (Type) <u>JAMES E. STONER, JR.</u>				<u>WALKERSVILLE, Md</u> <u>2/26/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/28/58</u>		22c. NAME OF CEMETERY OR CREMATORIUM <u>St. Luke's Lutheran</u>		22d. LOCATION (City, town, or county) (State) <u>Feagerville Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>G.C. Barton</u> ADDRESS <u>Walkersville, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 28 1958</u>		24b. REGISTRAR'S SIGNATURE <u>W. R. Smith</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the general director, TO FUNERAL DIRECTOR: This page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2006 CERTIFICATE OF DEATH

01965
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Foxville				c. LENGTH OF STAY IN 1b Lifetime			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				X c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Foxville (Smithsburg R.F.D.)			
				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First VIOLA Middle E Last DUNCAN				4. DATE OF DEATH Month Feb. Day II. Year 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 6 1869	
				9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Foxville, Fredk. Co., Md	
13. FATHER'S NAME Allen E. Hayes				14. MOTHER'S MAIDEN NAME Martha Kesselring			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. No			
				17. INFORMANT Address Mrs Fern Fox. Lantz, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal hypostatic broncho pneumonia 421.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Heart disease Chr. Valvular DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized arteriosclerosis							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) None							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I attended the deceased from Feb. 1 - , 19 58 , to Feb. 11 - , 19 58 , that I last saw the deceased alive on Feb. 11 - , 19 58 , and that death occurred at 10:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Thurmont, Md. DATE SIGNED							
ACTUAL SIGNATURE James K. Gray M.D. Thurmont, Md.							
PHYSICIAN'S NAME (Type) James K. Gray Thurmont, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 15, 1958		22c. NAME OF CEMETERY OR CREMATORY Mt. Bethel M.E. Cem		22d. LOCATION (City, town, or county) (State) Nr. Garfield, Fredk. Co., Md	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Cragg				ADDRESS Thurmont, MD			
24a. REC'D BY REGISTRAR DATE FEB 14 '58				24b. REGISTRAR'S SIGNATURE W. L. Smith			

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED VICTOR		2. SEX M		3. AGE 38	
4. DATE OF BIRTH JAN 11 1900		5. PLACE OF BIRTH BALTIMORE, MD.		6. OCCUPATION CLOCK REPAIRER	
7. DATE OF DEATH FEB 14 1953		8. PLACE OF DEATH BALTIMORE, MD.		9. CAUSE OF DEATH CORONARY THROMBOSIS	
10. MEDICAL HISTORY HYPERTENSION		11. PRESENT ILLNESS HEART ATTACK		12. SIGNATURE OF PHYSICIAN J. H. [Signature]	
13. SIGNATURE OF DECEASED [Signature]		14. SIGNATURE OF WITNESS [Signature]		15. SIGNATURE OF REGISTRAR [Signature]	

BUREAU V. S.

FEB 14 1953

RECEIVED

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1969 CERTIFICATE OF DEATH

Reg. Dist. No. 01966

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Since 2/20/58		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural RD#3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital				d. STREET ADDRESS Near Yellow Springs		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First NORMAN Middle LEWIS Last DUTROW, SR.				4. DATE OF DEATH Month February Day 25 Year 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 13 Aug 1890	9. AGE (In years last birthday) yrs. 67	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm Owner		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Granville M. Dutrow				14. MOTHER'S MAIDEN NAME Julia E. Hildebrand			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 219-36-4223		17. INFORMANT Address Mrs. Mary C. Dutrow (Same as item #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 350x IMMEDIATE CAUSE (a) Paralysis agitans DUE TO (b) Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)						INTERVAL BETWEEN ONSET AND DEATH 5 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 25, 1958 to Feb. 25, 1958 , that I last saw the deceased alive on Feb. 25, 1958 , and that death occurred at 1:15 A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE H. F. Kline				ADDRESS (Street, city or town, state) 7 N. Market St., Frederick, Md.		DATE SIGNED 2-26-58	
PHYSICIAN'S NAME (Type) H. F. Kline, M. D.				Frederick Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-28-58		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				24a. REC'D BY REGISTRAR DATE FEB 28 '58		24b. REGISTRAR'S SIGNATURE Alfred	

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

01967

1970

1. PLACE OF DEATH a. COUNTY FREDERICK MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY FREDERICK	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK		c. LENGTH OF STAY IN 1b DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JESSIE Middle MAY Last Eader		4. DATE OF DEATH Month Feb. Day 22 Year 1958	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 5 - 1893
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEKEEPER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	9. AGE (In years last birthday) 64 yrs.
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME CHARLES M EADER		14. MOTHER'S MAIDEN NAME IDA SHEETENHELM	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT EDNA E SMITH		Address LIBERTYTOWN MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (a Hemiplegia, it) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 14 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. 11. Month 19 Day 19 Year 1958 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from Feb. 20 , 19 58 , to 21 , 19 58 , that I last saw the deceased alive on Feb. 21 , 19 58 , and that death occurred at 9:50 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Bernard O. Thomas		ADDRESS (Street, city or town, state) 228 N Market St. Frederick, Md	
PHYSICIAN'S NAME (Type) Bernard O. Thomas Jr.		DATE SIGNED Feb. 22, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 2/24/58	22c. NAME OF CEMETERY OR CREMATORY FAIRMOUNT	22d. LOCATION (City, town, or county) (State) LIBERTYTOWN MD
23. FUNERAL DIRECTOR'S SIGNATURE DD Hartzler & Sons, Libertytown Md		24a. REC'D BY REGISTRAR DATE FEB 25 '58	
24b. REGISTRAR'S SIGNATURE Over			

BUREAU V. S.

FEB 25 1958

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

01968

1971

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	c. LENGTH OF STAY IN 1b Years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 31 Winchester Street		d. STREET ADDRESS 31 Winchester Street	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Also known as Eugene Frederick Elsroad) (Type or print) Eugene Frederick Elsroad		4. DATE OF DEATH Month February Day 17 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11 June 1893
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Night Watchman		10b. KIND OF BUSINESS OR INDUSTRY Fertilizer	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John Wesley Elsroad	
14. MOTHER'S MAIDEN NAME Victoria V. Hahn		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WWI	
16. SOCIAL SECURITY NO. 220-10-5166		17. INFORMANT Howard S. Fink, 27 N. Court St., Frederick, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Minutes			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE B. O. Thomas		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) B. O. Thomas, M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-21-58	
22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE FEB 20 1958	
		24b. REGISTRAR'S SIGNATURE	

DATE SIGNED

2-19-58

MDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

FEB 20 1953

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1972

CERTIFICATE OF DEATH

Reg. Dist. No. 01969

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 18 Years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) // Frederick			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 106 West Third Street		d. STREET ADDRESS 106 West Third Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JAMES Middle CRAWFORD Last EWING		4. DATE OF DEATH Month February Day 23, Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 20 July 1875
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Mechanical Engineer	
11. BIRTHPLACE (State or foreign country) Rhode Island		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Ewing		14. MOTHER'S MAIDEN NAME Jessie Primrose	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Mina A. Ewing (Same as item #1)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 177X Carcinomatosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of Prostate DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 9 months 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1, 1951, to Feb 23, 1958, that I last saw the deceased alive on Feb 23, 1958, and that death occurred at 12:15 P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Thomas E. Stone		ADDRESS (Street, city or town, state) 4 W. 3rd St., Frederick, Md.	
DATE SIGNED 2-24-58			
PHYSICIAN'S NAME (Type) Thomas E. Stone, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-26-58	
22c. NAME OF CEMETERY OR CREMATORY Frederick Memorial Park		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS	
24a. REC'D BY REGISTRAR DATE FEB 25 58		24b. REGISTRAR'S SIGNATURE	

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text]		SEX [Faint text]		AGE [Faint text]	
DATE OF DEATH [Faint text]		TIME OF DEATH [Faint text]		PLACE OF DEATH [Faint text]	
CAUSE OF DEATH [Faint text]		MANNER OF DEATH [Faint text]		PLACE OF BURIAL [Faint text]	
NAME OF PHYSICIAN [Faint text]		NAME OF MINISTER [Faint text]		NAME OF FUNERAL HOME [Faint text]	
NAME OF NEXT OF KIN [Faint text]		NAME OF SURVIVOR [Faint text]		NAME OF WITNESS [Faint text]	
NAME OF REGISTRAR [Faint text]		NAME OF CLERK [Faint text]		NAME OF ASSISTANT [Faint text]	
NAME OF DECEASED [Faint text]		SEX [Faint text]		AGE [Faint text]	
DATE OF DEATH [Faint text]		TIME OF DEATH [Faint text]		PLACE OF DEATH [Faint text]	
CAUSE OF DEATH [Faint text]		MANNER OF DEATH [Faint text]		PLACE OF BURIAL [Faint text]	
NAME OF PHYSICIAN [Faint text]		NAME OF MINISTER [Faint text]		NAME OF FUNERAL HOME [Faint text]	
NAME OF NEXT OF KIN [Faint text]		NAME OF SURVIVOR [Faint text]		NAME OF WITNESS [Faint text]	
NAME OF REGISTRAR [Faint text]		NAME OF CLERK [Faint text]		NAME OF ASSISTANT [Faint text]	

BUREAU V. 1

FEB 25 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **01970**

1. PLACE OF DEATH a. COUNTY Frederick 2007 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE North Carolina b. COUNTY Buncombe	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont-Rural		c. LENGTH OF STAY IN 1b Minutes	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Catoctin Furnace		d. STREET ADDRESS 18 1/2 East Chestnut Street	
3. NAME OF DECEASED (Type or print) First EARNEST Middle LEE Last FARR		4. DATE OF DEATH Month February Day 10 , Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 14 April 1914
9. AGE (In years last birthday) 43 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Trucking Co.	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk		16. SOCIAL SECURITY NO. 110-09-0221	
17. INFORMANT Paul Worley, Marshall, N. C.		Address Marshall, N. C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 823X Internal hemorrhage DOES TO rupture of liver (b) Fractured ribs on right side DOES TO Fracture of both legs & rt thigh (c) </div> <div style="width: 15%; text-align: center;"> INTERVAL BETWEEN ONSET AND DEATH 1 hour </div> </div>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH? <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Tractor ran in stone wall	
20c. TIME OF INJURY Month, Day, Year 5:15 a.m. 2/10 1958	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 15	20f. (City or town) (County) (State) Catoctin Furnace Frederick Md
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE B. O. Thomas		DATE SIGNED 2-11-58	
EXAMINER'S NAME (Type) B. O. Thomas, M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 2-11-58	
22c. NAME OF CEMETERY OR CREMATORY Marshall, North Carolina		22d. LOCATION (City, town, or county) (State) Marshall, North Carolina	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR FEB 13 58	
24b. REGISTRAR'S SIGNATURE W. H. Leach		DATE	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

FEB 13 1933

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1973

CERTIFICATE OF DEATH

Reg. Dist. No.

01971

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			c. LENGTH OF STAY IN 1b Hours	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural-R.F.D.#4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital				d. STREET ADDRESS Prospect Knoll		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Walter PAUL Feaga			4. DATE OF DEATH Month 2 Day 16 Year 1958				
5. SEX M	6. COLOR OR RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 9, 1892		9. AGE (In years last birthday) 65 yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming & Auto Salesman		10b. KIND OF BUSINESS OR INDUSTRY Farm & Auto Sales		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Edward Feaga			14. MOTHER'S MAIDEN NAME Elizabeth Agnes Unglebower				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-10-4835		17. INFORMANT Mrs. Maybelle G. Feaga-Same as Item # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Acute Coronary Thrombosis DUE TO (b) Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH 8 hours 2 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/16 , 19 58 , to 2/16 , 19 58 , that I last saw the deceased alive on 2/16 , 19 58 , and that death occurred at 10 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Henry V. Chase			M.D. 4 E. Church St		DATE SIGNED 2/16/58		
PHYSICIAN'S NAME (Type) Henry V. Chase			Frederick Md				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 20, 1958	22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				24a. REC'D BY REGISTRAR FEB 19 58		24b. REGISTRAR'S SIGNATURE W. H. Beach	

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1974

CERTIFICATE OF DEATH

Reg. Dist. No. 01972

1. PLACE OF DEATH a. COUNTY Frederick, Md. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick, Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick, Md.		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION none		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Martha Ella Free		4. DATE OF DEATH Month Day Year Feb. 18 1958	
5. SEX Female	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 20, 1871
9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 7 2	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James A. Richardson		14. MOTHER'S MAIDEN NAME Martha Ella Collins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) no	
17. INFORMANT Bradley T. Free		Address 376 Madison St. Frederick, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Senility</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2-3 years 2-3 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-1-1956, to 2-18-1958, that I last saw the deceased alive on 2-4-1958, and that death occurred at 10 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 35 E. Church Frederick, Md. 2-18-58 ACTUAL SIGNATURE <u>Robert C. Bailey Jr.</u> M.D. PHYSICIAN'S NAME (Type) <u>Rex B. Martin</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 22, 1958	
22c. NAME OF CEMETERY OR CREMATORY Rocky Springs Cemetery		22d. LOCATION (City, town, or county) (State) Frederick Co. Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert C. Bailey Jr.</u> ADDRESS 1201 3rd Market Frederick, Md.		24a. REC'D BY REGISTRAR DATE FEB 21 '58	
24b. REGISTRAR'S SIGNATURE <u>W. H. Leach</u>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH	
10. MANNER OF DEATH		11. PERMANENT RESIDENCE		12. TEMPORARY RESIDENCE	
13. OCCUPATION		14. EDUCATION		15. MARITAL STATUS	
16. PREVIOUS MARRIAGES		17. PREVIOUS DEATHS		18. PREVIOUS ILLNESSES	
19. PREVIOUS SURGERIES		20. PREVIOUS DRUGS		21. PREVIOUS ACCIDENTS	
22. PREVIOUS TRAUMAS		23. PREVIOUS INJURIES		24. PREVIOUS POISONING	
25. PREVIOUS INFECTIOUS DISEASES		26. PREVIOUS CHRONIC DISEASES		27. PREVIOUS ACUTE DISEASES	
28. PREVIOUS ALLERGIC REACTIONS		29. PREVIOUS IMMUNIZATIONS		30. PREVIOUS VACCINATIONS	
31. PREVIOUS TRANSFUSIONS		32. PREVIOUS ORGANS		33. PREVIOUS TISSUES	
34. PREVIOUS CELLS		35. PREVIOUS MOLECULES		36. PREVIOUS ATOMS	
37. PREVIOUS PARTICLES		38. PREVIOUS WAVES		39. PREVIOUS FIELDS	
40. PREVIOUS FORCES		41. PREVIOUS ENERGIES		42. PREVIOUS MOMENTUM	
43. PREVIOUS IMPULSES		44. PREVIOUS PRESSURES		45. PREVIOUS TEMPERATURES	
46. PREVIOUS HUMIDITIES		47. PREVIOUS PRESSURES		48. PREVIOUS GRAVITIES	
49. PREVIOUS ACCELERATIONS		50. PREVIOUS DECELERATIONS		51. PREVIOUS VIBRATIONS	
52. PREVIOUS OSCILLATIONS		53. PREVIOUS ROTATIONS		54. PREVIOUS TRANSLATIONS	
55. PREVIOUS REFLECTIONS		56. PREVIOUS REFRACTIONS		57. PREVIOUS DIFFRACTIONS	
58. PREVIOUS INTERFERENCES		59. PREVIOUS SCATTERINGS		60. PREVIOUS ABSORPTIONS	
61. PREVIOUS EMISSIONS		62. PREVIOUS ABSORPTIONS		63. PREVIOUS TRANSMISSIONS	
64. PREVIOUS REFLECTIONS		65. PREVIOUS REFRACTIONS		66. PREVIOUS DIFFRACTIONS	
67. PREVIOUS INTERFERENCES		68. PREVIOUS SCATTERINGS		69. PREVIOUS ABSORPTIONS	
70. PREVIOUS EMISSIONS		71. PREVIOUS ABSORPTIONS		72. PREVIOUS TRANSMISSIONS	
73. PREVIOUS REFLECTIONS		74. PREVIOUS REFRACTIONS		75. PREVIOUS DIFFRACTIONS	
76. PREVIOUS INTERFERENCES		77. PREVIOUS SCATTERINGS		78. PREVIOUS ABSORPTIONS	
79. PREVIOUS EMISSIONS		80. PREVIOUS ABSORPTIONS		81. PREVIOUS TRANSMISSIONS	
82. PREVIOUS REFLECTIONS		83. PREVIOUS REFRACTIONS		84. PREVIOUS DIFFRACTIONS	
85. PREVIOUS INTERFERENCES		86. PREVIOUS SCATTERINGS		87. PREVIOUS ABSORPTIONS	
88. PREVIOUS EMISSIONS		89. PREVIOUS ABSORPTIONS		90. PREVIOUS TRANSMISSIONS	
91. PREVIOUS REFLECTIONS		92. PREVIOUS REFRACTIONS		93. PREVIOUS DIFFRACTIONS	
94. PREVIOUS INTERFERENCES		95. PREVIOUS SCATTERINGS		96. PREVIOUS ABSORPTIONS	
97. PREVIOUS EMISSIONS		98. PREVIOUS ABSORPTIONS		99. PREVIOUS TRANSMISSIONS	
100. PREVIOUS REFLECTIONS		101. PREVIOUS REFRACTIONS		102. PREVIOUS DIFFRACTIONS	

RECEIVED
FEB 21 1958
BUREAU V. 1

2008

CERTIFICATE OF DEATH

01973

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Braddock Heights				c. LENGTH OF STAY IN 1b 6 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Vindobona Convalescent Home				d. STREET ADDRESS 728 Colorado Avenue			
3. NAME OF DECEASED (Type or print) First Elizabeth Middle M. Last Getzendanner				4. DATE OF DEATH Month February Day 7 Year 19 58			
5. SEX Female		6. COLOR OR RACE White		7. <input checked="" type="checkbox"/> MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-19-1879	
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Registered Nurse				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Milton E. Getzendanner				14. MOTHER'S MAIDEN NAME Clara Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Mrs. Ed. Grove-Sr.- W. 2nd. St.-Frederick-Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Stomach 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (with metastases liver) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1 year 6 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Sept 1 , 19 58 , to Feb 7 , 19 58 , that I last saw the deceased alive on Feb 6 , 19 58 , and that death occurred at 12:30 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Bernard O. Thomas Jr.				ADDRESS (Street, city or town, state) Frederick, Maryland			
DATE SIGNED 2/10/58							
PHYSICIAN'S NAME (Type) Dr. B.O. Thomas-Jr.				Professional Bldg.-Frederick-Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-10-1958		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C.E. Cline & Son				ADDRESS Frederick-Md.		24a. REC'D BY REGISTRAR DATE FEB 11 '58	
				24b. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL HOME: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
JAMES EARL RAY		Male		35		White		1928		Memphis, Tenn.		April 4, 1968		Jackson, Miss.		Shot		Suicide		J. Edgar Hoover		John P. ...	
13. OCCUPATION		14. EDUCATION		15. MARITAL STATUS		16. RELIGION		17. PREVIOUS ILLNESS		18. PREVIOUS SURGERY		19. PREVIOUS TRAUMA		20. PREVIOUS DRUGS		21. PREVIOUS ALCOHOL		22. PREVIOUS TOBACCO		23. PREVIOUS OTHER		24. PREVIOUS OTHER	
Attorney		High School		Married		Catholic		None		None		None		None		None		None		None		None	
25. SIGNATURE OF DECEASED		26. SIGNATURE OF WITNESS		27. SIGNATURE OF WITNESS		28. SIGNATURE OF WITNESS		29. SIGNATURE OF WITNESS		30. SIGNATURE OF WITNESS		31. SIGNATURE OF WITNESS		32. SIGNATURE OF WITNESS		33. SIGNATURE OF WITNESS		34. SIGNATURE OF WITNESS		35. SIGNATURE OF WITNESS		36. SIGNATURE OF WITNESS	

1

BUREAU V. S.

FEB 11 1968

RECEIVED

MEDICAL CERTIFICATION

VS A15 (4)
15M 9/55

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1975

CERTIFICATE OF DEATH

01975

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Fred.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ijamsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hosp.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Pamela Kaye Hallman		4. DATE OF DEATH Month Day Year Feb 14 19 58	
5. SEX F	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-12-58
9. AGE (In years last birthday) yrs. 2		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Day Hours Min. 2	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Wayne Augustus Chase		14. MOTHER'S MAIDEN NAME Jane Esther Hallman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) ***		16. SOCIAL SECURITY NO. *****	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoid hemorrhage 760.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Malrotation of intestines		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-12-58 , 19 58 , to 2-14-58 , 19 58 , that I last saw the deceased alive on 2-14-58 , and that death occurred at 4 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Fredrich M.D.			
PHYSICIAN'S NAME (Type) F.J.Heldrich, M.D. Frederick Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-15-58	
22c. NAME OF CEMETERY OR CREMATORY Fairview		22d. LOCATION (City, town, or county) (State) Frederick, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Hicks III		24a. REC'D BY REGISTRAR Feb 25 '58	
24b. REGISTRAR'S SIGNATURE Fredrich			

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
J		M		23		1915		BALTIMORE		MD		USA			
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS		TREATMENT	
1938		10:00 AM		HOME		HEART DISEASE		SUDDEN		CORONARY ARTERY DISEASE		PAIN IN CHEST		NO	
DATE OF INTERMENT		TIME OF INTERMENT		PLACE OF INTERMENT		CITY		STATE		COUNTRY		CITY		STATE	
1938		10:00 AM		CATHOLIC CHURCH		BALTIMORE		MD		USA		BALTIMORE		MD	
NAME OF MINISTER		NAME OF CLERGYMAN		NAME OF CLERGYMAN		NAME OF CLERGYMAN		NAME OF CLERGYMAN		NAME OF CLERGYMAN		NAME OF CLERGYMAN		NAME OF CLERGYMAN	
J		M		23		1915		BALTIMORE		MD		USA			
DATE OF INTERMENT		TIME OF INTERMENT		PLACE OF INTERMENT		CITY		STATE		COUNTRY		CITY		STATE	
1938		10:00 AM		CATHOLIC CHURCH		BALTIMORE		MD		USA		BALTIMORE		MD	
NAME OF MINISTER		NAME OF CLERGYMAN		NAME OF CLERGYMAN		NAME OF CLERGYMAN		NAME OF CLERGYMAN		NAME OF CLERGYMAN		NAME OF CLERGYMAN		NAME OF CLERGYMAN	
J		M		23		1915		BALTIMORE		MD		USA			

BUREAU V. 3

1938 25 1938

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1976

CERTIFICATE OF DEATH

Reg. Dist. No. 01976

1. PLACE OF DEATH o. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Hwy Market</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ella</u> Middle <u>Lavinia</u> Last <u>Harshman</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>12</u> Year <u>1958</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 1, 1891</u>	9. AGE (In years lost birthday) <u>67</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Josiah Burrier</u>				14. MOTHER'S MAIDEN NAME <u>Lavinia LONG</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Harry H. Harshman New Market</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> <u>4200</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>1 yr +</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2/12/58</u> , 19 <u>58</u> , to <u>2/12/58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>2/12</u> , 19 <u>58</u> , and that death occurred at <u>530 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Henry V Chase</u> M.D.				ADDRESS (Street, city or town, state) <u>4 E. Church St</u> DATE SIGNED <u>2/12/58</u>			
PHYSICIAN'S NAME (Type) <u>Henry V. Chase</u>				<u>Frederick MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>FEB 15-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BRETHERN CEMETERY MONROVIA</u>		22d. LOCATION (City, town, or county) (State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>W. E. Salcorer New Market MD</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 24 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. E. Salcorer</u>	

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED _____</p>		<p>2. SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE</p>	
<p>3. AGE _____</p>		<p>4. DATE OF BIRTH _____</p>	
<p>5. PLACE OF BIRTH _____</p>		<p>6. DATE OF DEATH _____</p>	
<p>7. TIME OF DEATH _____</p>		<p>8. PLACE OF DEATH _____</p>	
<p>9. CAUSE OF DEATH _____</p>		<p>10. MANNER OF DEATH <input type="checkbox"/> NATURAL <input type="checkbox"/> ACCIDENTAL <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE</p>	
<p>11. SIGNATURE OF PHYSICIAN _____</p>		<p>12. SIGNATURE OF REGISTRAR _____</p>	
<p>13. SIGNATURE OF WITNESS _____</p>		<p>14. SIGNATURE OF DECEASED _____</p>	

BUREAU V. 1

FEB 24 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1977

CERTIFICATE OF DEATH

Reg. Dist. No.

01977

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
c. LENGTH OF STAY IN TB 50 Years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8 Monroe Avenue		d. STREET ADDRESS 8 Monroe Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LEWIS Middle ELMER Last HEERD		4. DATE OF DEATH Month February Day 9 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 21, 1885
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tool Grinder		10b. KIND OF BUSINESS OR INDUSTRY Brush Company	
11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Louis C. Heerd		14. MOTHER'S MAIDEN NAME Annie M. Schaum	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-10-2336	
17. INFORMANT Mrs. Mamie G. Heerd, Same as item #1		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Barney Accidents 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chl Myocardium & Arteriosclerosis DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 mo 10 yrs			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-2 , 19 40 to 2-9 , 19 58 , that I last saw the deceased alive on 2-8 , 19 58 , and that death occurred at 8:15A , M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) West All Saints Street DATE SIGNED 2/10/58			
ACTUAL SIGNATURE U. G. Bourne Jr		M.D. West All Saints Street	
PHYSICIAN'S NAME (Type) Dr. U. G. Bourne, Jr.		Frederick, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 12, 1958	
22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE FEB 11 '58	
24b. REGISTRAR'S SIGNATURE W. H. E. E. E.			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01978

Reg. Dist. No.

2410 Items 13, 14, Film 226 3-17-58 et

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Frederick County</u> <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Route 97 3 miles East of Tayentown</u>		c. LENGTH OF STAY IN 1b <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DOA Frederick Memorial Hospital</u>		e. STREET ADDRESS <u>3002 Chesterfield Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Elmer</u> Middle <u>L</u> Last <u>Hobbs</u>		4. DATE OF DEATH Month <u>February</u> Day <u>15</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 16, 1886</u> 72 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>tool & die maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Benedict Hobbs</u>		14. MOTHER'S MAIDEN NAME <u>Mary Virginia Ringgold</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Elmer H. Hobbs</u>		Address <u>2512 Moore Ave. Balto. 14</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture base of skull</u> <u>824 x</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Thrown out of car wheels of car ran over neck</u>	
20c. TIME OF INJURY Month, Day, Year <u>How</u> <u>3</u> <u>am</u> <u>2/15/58</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, hotel, etc.) <u>Route 97</u>		20f. (City or town) (County) (State) <u>Nr. Taneytown Carroll Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>B.O. Thomas</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>B.O. Thomas, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>2/15/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>2/20/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ullrich Funeral Homes, Balto., Md.</u>		ADDRESS <u>Ullrich Funeral Homes, Balto., Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>FEB 24 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Alb. Leach</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU 38
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED

RESIDENCE

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY INTO STATE

DATE OF DEPARTURE FROM STATE

DATE OF RETURN TO STATE

DATE OF DEATH

DATE OF BURIAL

DATE OF CREMATION

DATE OF INTERMENT

DATE OF EXHUMATION

DATE OF REINTERMENT

BUREAU 38

FEB 24 1958

RECEIVED

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH

a. COUNTY

Frederick

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Flint Hill
Adamstown R.F.D. I

c. LENGTH OF STAY IN 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Maryland

b. COUNTY

Frederick

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

X Flint Hill
Adamstown R.F.D. I

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

d. STREET ADDRESS

e. IS RESIDENCE
ON A FARM?
YES ☐ NO ☒

3. NAME OF
DECEASED
(Type or print)

First
Elba

Middle
Christine

Last
Holland

4. DATE
OF
DEATH

Month
February

Day
I

Year
19 58

5. SEX

Female

6. COLOR OR RACE

Colored

7. MARRIED ☐ NEVER MARRIED ☒

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

December 20, 1930 27 yrs.

9. AGE (In years
last birthday)

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Domestic

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Irving Holland

14. MOTHER'S MAIDEN NAME

Catherine Lee

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)

No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

Unknown

17. INFORMANT

Address

John Holland Adamstown R.F.D. I, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Uterine Hemorrhage

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

Child Birth

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY
PERFORMED?
YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS
PRIMARY ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY

Month, Day, Year

Hour
a. m.
p. m.

19

20d. INJURY OCCURRED

While
at work ☐ Not while
at work ☐

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE

B.O. Thomas

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

February 1, 1958

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF

2-4-58

22c. NAME OF CEMETERY OR CREMATORY

Hopehill

22d. LOCATION (City, town, or county)

Frederick-Co., Md.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

Charles E. Hicks 111 Frederick-Md.

24a. REC'D BY REGISTRAR

DATE

24b. REGISTRAR'S SIGNATURE

Feb 1 1958

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be furnished to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND
HEALTH DEPT.

RECEIVED
FEB 10 1959
BUREAU V. S.

STATE OF MARYLAND
HEALTH DEPT.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME: [illegible]
AGE: [illegible]
SEX: [illegible]
RACE: [illegible]
DATE OF BIRTH: [illegible]
DATE OF DEATH: [illegible]
PLACE OF BIRTH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE: [illegible]
DATE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1978

CERTIFICATE OF DEATH

01980

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			c. LENGTH OF STAY IN 1b. 4 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural-R.D.#3		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital				d. STREET ADDRESS Bloomfield		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CLAUDE Middle STANLEY Last HOLTZ				4. DATE OF DEATH Month February Day 12 Year 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 10, 1894		9. AGE (In years lost birthday) 63 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Granville C. Holtz				14. MOTHER'S MAIDEN NAME Addie Wachter			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WWL		17. INFORMANT Mr. Carl E. Holtz, Frederick R. F. D. #3, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho Pneumonia DUE TO Shock Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fracture Hip (c) 4 days							INTERVAL BETWEEN ONSET AND DEATH 4 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell in nursing home					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Nursing home		20f. (City or town) (County) (State) Frederick Co	
21. I certify that I attended the deceased from Feb 8, 1957 to Feb 12, 1957 , that I last saw the deceased alive on Feb 12, 1957 , and that death occurred at 7:15 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE EP Thomas				ADDRESS (Street, city or town, state) East Church Street,		DATE SIGNED 2/14/58	
PHYSICIAN'S NAME (Type) Dr. E. P. Thomas, Sr. Frederick, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 15, 1958		22c. NAME OF CEMETERY OR CREMATORY Zion Cemetery		22d. LOCATION (City, town, or county) (State) Frederick County, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				24a. REC'D BY REGISTRAR DATE FEB 14 58		24b. REGISTRAR'S SIGNATURE W. Search	

1979

CERTIFICATE OF DEATH

Reg. Dist. No.

MEDICAL CERTIFICATION

VS A15 (4)
15M 9/SS

CERTIFICATE OF DEATH

PLACE OF DEATH		MARRIAGE	
1. CITY OR TOWN		2. COUNTY	
3. STATE		4. DISTRICT	
5. ZIP CODE		6. DEATH NO.	
7. DATE OF DEATH		8. TIME OF DEATH	
9. PLACE OF DEATH		10. CAUSE OF DEATH	
11. MANNER OF DEATH		12. MEDICAL HISTORY	
13. PREVIOUS ILLNESS		14. SURGICAL HISTORY	
15. PREVIOUS SURGERY		16. PREVIOUS TRAUMA	
17. PREVIOUS DRUGS		18. PREVIOUS ALCOHOL	
19. PREVIOUS TOBACCO		20. PREVIOUS OTHER	
21. PREVIOUS OTHER		22. PREVIOUS OTHER	
23. PREVIOUS OTHER		24. PREVIOUS OTHER	
25. PREVIOUS OTHER		26. PREVIOUS OTHER	
27. PREVIOUS OTHER		28. PREVIOUS OTHER	
29. PREVIOUS OTHER		30. PREVIOUS OTHER	
31. PREVIOUS OTHER		32. PREVIOUS OTHER	
33. PREVIOUS OTHER		34. PREVIOUS OTHER	
35. PREVIOUS OTHER		36. PREVIOUS OTHER	
37. PREVIOUS OTHER		38. PREVIOUS OTHER	
39. PREVIOUS OTHER		40. PREVIOUS OTHER	
41. PREVIOUS OTHER		42. PREVIOUS OTHER	
43. PREVIOUS OTHER		44. PREVIOUS OTHER	
45. PREVIOUS OTHER		46. PREVIOUS OTHER	
47. PREVIOUS OTHER		48. PREVIOUS OTHER	
49. PREVIOUS OTHER		50. PREVIOUS OTHER	
51. PREVIOUS OTHER		52. PREVIOUS OTHER	
53. PREVIOUS OTHER		54. PREVIOUS OTHER	
55. PREVIOUS OTHER		56. PREVIOUS OTHER	
57. PREVIOUS OTHER		58. PREVIOUS OTHER	
59. PREVIOUS OTHER		60. PREVIOUS OTHER	
61. PREVIOUS OTHER		62. PREVIOUS OTHER	
63. PREVIOUS OTHER		64. PREVIOUS OTHER	
65. PREVIOUS OTHER		66. PREVIOUS OTHER	
67. PREVIOUS OTHER		68. PREVIOUS OTHER	
69. PREVIOUS OTHER		70. PREVIOUS OTHER	
71. PREVIOUS OTHER		72. PREVIOUS OTHER	
73. PREVIOUS OTHER		74. PREVIOUS OTHER	
75. PREVIOUS OTHER		76. PREVIOUS OTHER	
77. PREVIOUS OTHER		78. PREVIOUS OTHER	
79. PREVIOUS OTHER		80. PREVIOUS OTHER	
81. PREVIOUS OTHER		82. PREVIOUS OTHER	
83. PREVIOUS OTHER		84. PREVIOUS OTHER	
85. PREVIOUS OTHER		86. PREVIOUS OTHER	
87. PREVIOUS OTHER		88. PREVIOUS OTHER	
89. PREVIOUS OTHER		90. PREVIOUS OTHER	
91. PREVIOUS OTHER		92. PREVIOUS OTHER	
93. PREVIOUS OTHER		94. PREVIOUS OTHER	
95. PREVIOUS OTHER		96. PREVIOUS OTHER	
97. PREVIOUS OTHER		98. PREVIOUS OTHER	
99. PREVIOUS OTHER		100. PREVIOUS OTHER	

BUREAU V. S.

FEB 27 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **01982**

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Frederick <div style="text-align: right;">MARYLAND</div>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital		e. STREET ADDRESS 149 Fairview Ave.	
3. NAME OF DECEASED (Type or print) James		4. DATE OF DEATH Month Feb. Day 9 Year 1958	
5. SEX Male		6. COLOR OR RACE W	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 19, 1948	
9. AGE (In years last birthday) 9 yrs.		10. IF UNDER 1 YEAR Months 9 Days 15 Hours 58 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Frederick, Co., USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Carrol L. Horine		14. MOTHER'S MAIDEN NAME Vera Maxson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage 844.X DUE TO <div style="display: flex; align-items: center;"> <div style="border-left: 1px solid black; padding-left: 5px; margin-right: 5px;"> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. </div> <div style="margin-left: 5px;"> (b) Rupture and torn liver and spleen (c) </div> </div> </p> </div> <div style="width: 15%; text-align: center;"> INTERVAL BETWEEN ONSET AND DEATH 4 hrs. 4 hrs. </div> </div>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Was sledding; ran into a culvert.	
20c. TIME OF INJURY Month, Day, Year Hour 6 m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) on farm		20f. (City or town) (County) (State) nr Myersville, Fred. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE B. O. Thomas		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) B. O. Thomas, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED February 10, 58	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 2/12/1958	
22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Gladhill Co., Middletown, Md.		ADDRESS	
24a. REC'D BY REGISTRAR DATE FEB 13 '58		24b. REGISTRAR'S SIGNATURE W. J. ...	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
1981
CERTIFICATE OF DEATH

01983

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mount Airy Rural RD#3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		d. STREET ADDRESS Plane #4	
3. NAME OF DECEASED (Type or print) MORIELL First I. Middle JONES Last Moriell I. JONES		4. DATE OF DEATH Month Feb. Day 2 Year 1958	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unknown
9. AGE (In years last birthday) 62? yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles E. Jones		14. MOTHER'S MAIDEN NAME Annie Purdum	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Edward M. Smith, Frederick, Md.		221 Center St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Venous thrombosis (c) Arteriosclerotic heart disease, decompensated		INTERVAL BETWEEN ONSET AND DEATH 3-4 days Prob. sev. years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Malnutrition			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 30 , 19 58 , to Feb 2 , 19 58 , that I last saw the deceased alive on Feb 1 , 19 58 , and that death occurred at 2:10 A . M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 2/2/58			
ACTUAL SIGNATURE Ralph L. Michels M.D.			
PHYSICIAN'S NAME (Type) Ralph L. Michels MD		New Market, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-5-58	22c. NAME OF CEMETERY OR CREMATORY Providence Cemetary	22d. LOCATION (City, town, or county) (State) Kemptown, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE M.B. Etchison & Son, Frederick, Maryland		ADDRESS	
24a. REC'D BY REGISTRAR FEB 6 '58		24b. REGISTRAR'S SIGNATURE Alb. Search	

BUREAU V. S.

FEB 6 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2012 CERTIFICATE OF DEATH

Reg. Dist. No.

01984

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Emmitsburg,		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION DePaul Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Francis Last Kelly		4. DATE OF DEATH Month February Day 17 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 28, 1871
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months 86 Days 86 Hours 86 Min. 86	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Broom maker		10b. KIND OF BUSINESS OR INDUSTRY Frederick Co. Md.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jerome F. Kelly		14. MOTHER'S MAIDEN NAME Mary Peddicord	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-30-5733	
17. INFORMANT Alice G. Kelly		Address Emmitsburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 5 minutes	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 22 , 1956, to Feb 17 , 1958, that I last saw the deceased alive on Feb 6 , 1958, and that death occurred at 6:40 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles R Williams M.D.		ADDRESS (Street, city or town, state) Emmitsburg Md DATE SIGNED 2-18-58	
PHYSICIAN'S NAME (Type) Charles R Williams			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/20/1958	
22c. NAME OF CEMETERY OR CREMATORY St. Joseph's Catholic		22d. LOCATION (City, town, or county) (State) Emmitsburg, Frederick Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE S. L. Allison		24a. RECEIVED BY REGISTRAR Emmitsburg, Md. DATE	
24b. REGISTRAR'S SIGNATURE			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. S.

FEB 20 1953

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

01985

1982

1. PLACE OF DEATH a. COUNTY Frederick County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hosp.				d. STREET ADDRESS 628 Grant Place			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First MINNA Middle FAUL Last KNOLL				4. DATE OF DEATH Month Feb. Day 4 Year 1958			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 9, 1886		9. AGE (In years last birthday) 71 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Alfred J. Faul				14. MOTHER'S MAIDEN NAME Minna Caspari			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Alfred J. Knoll - 628 Grant Pl., Frederick Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive intracerebral heart disease 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 2 yrs.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-1- , 1955 , to 2-3- , 1958 , that I last saw the deceased alive on 2-3- , 1958 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 35 E. Church DATE SIGNED Md							
ACTUAL SIGNATURE Rex R Martin M.D.				PHYSICIAN'S NAME (Type) Frederick Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/7/58		22c. NAME OF CEMETERY OR CREMATORY London Park Cem.		22d. LOCATION (City, town, or county) (State) Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tucker & Sons - Balto				24. REC'D BY REGISTRAR DATE FEB 6 '58		24b. REGISTRAR'S SIGNATURE Overland	

BUREAU

FEB. 6. 1958

RECEIVED
JUN 6 1958

1983 CERTIFICATE OF DEATH

Reg. Dist. No. 01986

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b Frederick-Rural RD#4			
d. NAME OF HOSPITAL (If not in hospital, give street address) Frederick Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CHARLES Middle EDWARD Last LAMM				4. DATE OF DEATH Month February Day 2 Year 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 23 Oct 1874	
9. AGE (In years last birthday) yrs. 83		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME Soloman Lamm				14. MOTHER'S MAIDEN NAME Henrietta Cook			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 220-09-8146		17. INFORMANT Mrs. Mary E. Lamm (Same as item #2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary & Generalized Edema 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocarditis & Decompensated DUE TO (c) Generalized Arteriosclerosis				INTERVAL BETWEEN ONSET AND DEATH 1 wk 3 mo 2 y 10			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Nov , 19 57 , to Feb 2 , 19 58 , that I last saw the deceased alive on Feb 1 , 19 58 , and that death occurred at 5:30A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE A. T. Brice M.D.				ADDRESS (Street, city or town, state) Jefferson, Md.		DATE SIGNED 2-4-58	
PHYSICIAN'S NAME (Type) A. T. Brice, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-5-58		22c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery		22d. LOCATION (City, town, or county) (State) Jefferson, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				ADDRESS Frederick, Maryland		24a. REC'D BY REGISTRAR FEB 6 58	
				24b. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 6 1953

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2013 CERTIFICATE OF DEATH

Reg. Dist. No.

01987

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Knoxville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Knoxville	
d. NAME OF HOSPITAL (If not in hospital, give street address) Knoxville		d. STREET ADDRESS Knoxville	
3. NAME OF DECEASED (Type or print) Gertrude First Lewis Middle - Last		4. DATE OF DEATH Feb. Month 17 Day 19 Year 58	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 1, 1878
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Weverton, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Harrison		14. MOTHER'S MAIDEN NAME Caroline (unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, <input checked="" type="checkbox"/> No <input type="checkbox"/> unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. -	
17. INFORMANT Mrs. Albert Miller		Address Knoxville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral 592X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Hypertensive Hypertension DUE TO (c) -		INTERVAL BETWEEN ONSET AND DEATH 1 week 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/13 , 19 57 , to 2/17 , 19 58 , that I last saw the deceased alive on 2/12 , 19 58 , and that death occurred at 7:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE [Signature]		ADDRESS (Street, city or town, state) Louisa, Va.	
DATE SIGNED 2/18/58			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 19	
22c. NAME OF CEMETERY OR CREMATORY Reformed		22d. LOCATION (City, town, or county) (State) Knoxville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Elva V. Feste		ADDRESS Brunswick, Md.	
24a. REC'D BY REGISTRAR DATE FEB 24 '58		24b. REGISTRAR'S SIGNATURE [Signature]	

BUREAU V. E.

FFB 64 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1984 CERTIFICATE OF DEATH

01988

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>			c. LENGTH OF STAY IN 1b <u>51 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>206 East 6th Street</u>				d. STREET ADDRESS <u>206 East 6th Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Gertie</u> Middle <u>Emma</u> Last <u>Lipps</u>				4. DATE OF DEATH Month <u>February</u> Day <u>19th</u> Year <u>19 58</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> RE-MARRIED		8. DATE OF BIRTH <u>Sept. 22-1879</u>		
9. AGE (In years last birthday) <u>78 yrs.</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		
10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>Claggett Albert Waltz</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Elizabeth Ernst</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mr. Maynard V. Lipps-206 E. 6th St.-Frederick-Md.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular Accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Senility</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u> <u>5 yrs.</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 10, 1955</u> , to <u>Feb 19, 1958</u> , that I last saw the deceased alive on <u>Feb 18, 1958</u> , and that death occurred at <u>2 30</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>35 E. Church Frederick MD</u> DATE SIGNED <u>2-19-58</u>								
ACTUAL SIGNATURE <u>Rex R Martin</u> M.D.				PHYSICIAN'S NAME (Type) <u>Rex R Martin</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-22-1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Frederick-Maryland</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. E. Cline & Son</u> ADDRESS <u>Frederick-Maryland</u>				24a. REC'D BY REGISTRAR <u>FEB 21 58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Church</u>		

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES EARL RAY		35		M		W		1928		MEMPHIS		TENNESSEE		UNITED STATES		UNITED STATES	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH	
APRIL 4, 1968		MEMPHIS		MEMPHIS		TENNESSEE		UNITED STATES		APRIL 4, 1968		MEMPHIS		MEMPHIS		TENNESSEE	
TIME OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY		DISEASE OR INJURY		DISEASE OR INJURY		DISEASE OR INJURY		DISEASE OR INJURY		DISEASE OR INJURY	
10:00 PM		SHOOTING		SUICIDE		GUNSHOT WOUND		GUNSHOT WOUND		GUNSHOT WOUND		GUNSHOT WOUND		GUNSHOT WOUND		GUNSHOT WOUND	
PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH	
MEMPHIS		MEMPHIS		TENNESSEE		UNITED STATES		APRIL 4, 1968		MEMPHIS		MEMPHIS		TENNESSEE		UNITED STATES	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH	
APRIL 4, 1968		MEMPHIS		MEMPHIS		TENNESSEE		UNITED STATES		APRIL 4, 1968		MEMPHIS		MEMPHIS		TENNESSEE	
TIME OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY		DISEASE OR INJURY		DISEASE OR INJURY		DISEASE OR INJURY		DISEASE OR INJURY		DISEASE OR INJURY	
10:00 PM		SHOOTING		SUICIDE		GUNSHOT WOUND		GUNSHOT WOUND		GUNSHOT WOUND		GUNSHOT WOUND		GUNSHOT WOUND		GUNSHOT WOUND	
PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH	
MEMPHIS		MEMPHIS		TENNESSEE		UNITED STATES		APRIL 4, 1968		MEMPHIS		MEMPHIS		TENNESSEE		UNITED STATES	

BUREAU V. 51

FEB 21 1968

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film G226 2-28-58 et

2014

CERTIFICATE OF DEATH

01989

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>rural Ijansville</u>			c. LENGTH OF STAY IN 1b <u>12 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Sabillisville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Riggs Hospital</u>				d. STREET ADDRESS <u>rural</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Lorene V Lohr</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>16</u> Year <u>1958</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 12, 1885</u>	9. AGE (In years last birthday) <u>72</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife-Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Illinois-(Mantena)</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Mortimer</u>				14. MOTHER'S MAIDEN NAME <u>Susan Montague</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT <u>Dr. Gerald M. Isbell</u> Address <u>Baltimore, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>420.0</u> IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>---</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>---</u>		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>Feb 4</u> , 19 <u>58</u> , to <u>Feb 16</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Feb 16</u> , 19 <u>58</u> , and that death occurred at <u>4:00</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Ijansville MD</u> DATE SIGNED <u>Feb 16 58</u> ACTUAL SIGNATURE <u>Joseph Lerner</u> M.D. PHYSICIAN'S NAME (Type) <u>Joseph Lerner M.D.</u>							
22a. BURIAL, CREMATION, or other disposition (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 21, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Park Heights Cemetery, Brunswick, Maryland</u>		22d. LOCATION (City, town, or county) _____ (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Elva D. Feete</u> ADDRESS <u>Brunswick, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 24 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. J. Beach</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED JOHN J. JAMES		2. SEX MALE	
3. DATE OF BIRTH JAN 15 1895		4. PLACE OF BIRTH BALTIMORE, MD	
5. OCCUPATION LABORER		6. MARITAL STATUS MARRIED	
7. DATE OF DEATH FEB 24 1958		8. PLACE OF DEATH BALTIMORE, MD	
9. CAUSE OF DEATH HEART DISEASE		10. MEDICAL HISTORY HYPERTENSION	
11. SIGNATURE OF PHYSICIAN DR. J. J. JAMES		12. SIGNATURE OF WITNESSES DR. J. J. JAMES	
13. SIGNATURE OF REGISTRAR BUREAU Y. F.		14. SIGNATURE OF DECEASED JOHN J. JAMES	

RECEIVED

FEB 24 1958

BUREAU Y. F.

1985

CERTIFICATE OF DEATH

01990

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 6 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 113 E. 5th Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Hayes Last Luby		4. DATE OF DEATH Month Feb. Day 8 Year 1958	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 9- 1885
9. AGE (In years from birthday) yrs. 72		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer-Lime Co.		10b. KIND OF BUSINESS OR INDUSTRY *****	
11. BIRTHPLACE (State or foreign country) Frederick Co. Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John W. Luby		14. MOTHER'S MAIDEN NAME Mollie Freeland	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217-07-0737	
17. INFORMANT Vannie E. Luby--113 E. 5th Street Fred. Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 444X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Essential hypertension DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH Months years -		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/7 , 19 58 , to 2/8 , 19 58 , that I last saw the deceased alive on 2/7 , 19 58 , and that death occurred at M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 228 N. Market St. - Frederick, Md. DATE SIGNED 2/10/58			
ACTUAL SIGNATURE James B. Thomas		PHYSICIAN'S NAME (Type) James B. Thomas	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 11-58	
22c. NAME OF CEMETERY OR CREMATORY Fairview		22d. LOCATION (City, town, or county) (State) Frederick, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Hicks		ADDRESS 111 Frederick, Md.	
24a. REC'D BY REGISTRAR Feb 14 '58		24b. REGISTRAR'S SIGNATURE Charles E. Hicks	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John A. Jones		Male		45		Jan 15, 1900		Baltimore, Md.	
Cause of Death		Immediate Cause		Underlying Cause		Manner of Death		Place of Death	
Heart Disease		Coronary Artery Disease		Myocardial Infarction		Natural		Home	
Date of Death		Time of Death		Place of Death		Physician's Signature		Hospital or Institution	
Feb 10, 1958		10:30 AM		Home		J. A. Smith, M.D.		None	
Burial or Disposition		Burial		Cremation		Other		Place of Burial	
Buried		Yes		No		No		St. John's Cemetery	
Signature of Registrar		Signature of Physician		Signature of Coroner		Signature of Medical Examiner		Signature of Death Investigator	
J. A. Smith, M.D.		J. A. Smith, M.D.		J. A. Smith, M.D.		J. A. Smith, M.D.		J. A. Smith, M.D.	

BUREAU V. S.

FEB 14 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1986 CERTIFICATE OF DEATH

01991

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 7 Days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		d. STREET ADDRESS 134 West Patrick Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle ANN Last MILYARD		4. DATE OF DEATH Month February Day 15 , Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 27, 1883
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Adam Bell		14. MOTHER'S MAIDEN NAME Jane Elizabeth Murphy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None	
17. INFORMANT Mr. Gordon H. Milyard-Same as Item #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolism DUE TO Thrombo phlebitis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) (c)		INTERVAL BETWEEN ONSET AND DEATH Minutes Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. s. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/10 , 19 58 , to 2/15 , 19 58 , that I last saw the deceased alive on 2/15 , 19 58 , and that death occurred at 4:25 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Professional Building, Frederick, Maryland DATE SIGNED 2/18/1958 ACTUAL SIGNATURE James B. Thomas M.D. PHYSICIAN'S NAME (Type) Dr. James B. Thomas			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 19, 1958	
22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE FEB 19 '58	
24b. REGISTRAR'S SIGNATURE W. H. Beach			

CERTIFICATE OF DEATH

Reg. Div. 112

DATE OF DEATH		PLACE OF DEATH	
FEB 19 1939		BALTIMORE	
DECEASED		SEX	
MALE		MALE	
AGE		RACE	
35		WHITE	
BIRTH DATE		BIRTH PLACE	
FEB 19 1904		BALTIMORE	
OCCUPATION		CAUSE OF DEATH	
LABORER		HEART DISEASE	
MANNER OF DEATH		MEDICAL ATTENDANCE	
NATURAL		YES	
DATE OF BURIAL		PLACE OF BURIAL	
FEB 20 1939		BALTIMORE	
NAME OF FUNERAL HOME		NAME OF MINISTER	
J. J. JONES		J. J. JONES	
NAME OF NEXT OF KIN		NAME OF PHYSICIAN	
J. J. JONES		J. J. JONES	
ADDRESS		CITY	
1234 MAIN ST.		BALTIMORE	
STATE		COUNTY	
MD		BALTIMORE	

RECEIVED
FEB 19 1939
BUREAU V. S.

1992

1987 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>FREDERICK</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>FREDERICK</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FREDERICK</u>				c. LENGTH OF STAY IN 1b <u>2 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FREDERICK Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>James Brooke PARKINSON</u>				4. DATE OF DEATH Month Day Year <u>Feb 19 1958</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 17, 1958</u>	
9. AGE (In years last birthday) yrs. <u>2</u>		IF UNDER 1 YEAR Months Days Hours Min. <u>2</u>		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
				11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Edwin Brooke PARKINSON JR</u>				14. MOTHER'S MAIDEN NAME <u>Shirley Anne Aeschbacher</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
				17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fetal Atelectasis</u> <u>762.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>12 PM</u> , 19 <u>58</u> , to <u>1:50 PM</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>1/15/58</u> , 19 <u>58</u> , and that death occurred at <u>2:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Am Powell Jr</u> M.D. <u>220 N. MARKET ST. 2-19-58</u> PHYSICIAN'S NAME (Type) <u>AM. Powell M.D.</u> <u>FREDERICK - Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>2-20-1958</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET Cemetery</u>				22d. LOCATION (City, town, or county) (State) <u>FREDERICK - Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. E. Cline & Son</u>				ADDRESS <u>FREDERICK - Md.</u>			
24a. REC'D BY REGISTRAR <u>DATE FEB 21 '58</u>				24b. REGISTRAR'S SIGNATURE <u>W. H. Smith</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2269222XV4

CERTIFICATE OF DEATH

Form 100-100

<p>1. NAME OF DECEASED [Blank]</p>		<p>2. SEX [Blank]</p>		<p>3. RACE [Blank]</p>	
<p>4. DATE OF BIRTH [Blank]</p>		<p>5. PLACE OF BIRTH [Blank]</p>		<p>6. PLACE OF DEATH [Blank]</p>	
<p>7. DATE OF DEATH [Blank]</p>		<p>8. TIME OF DEATH [Blank]</p>		<p>9. PLACE OF DEATH [Blank]</p>	
<p>10. CAUSE OF DEATH [Blank]</p>		<p>11. MANNER OF DEATH [Blank]</p>		<p>12. PLACE OF DEATH [Blank]</p>	
<p>13. NAME OF PHYSICIAN [Blank]</p>		<p>14. NAME OF HOSPITAL [Blank]</p>		<p>15. NAME OF NURSE [Blank]</p>	
<p>16. NAME OF CORONER [Blank]</p>		<p>17. NAME OF JURY [Blank]</p>		<p>18. NAME OF JURY [Blank]</p>	
<p>19. NAME OF JURY [Blank]</p>		<p>20. NAME OF JURY [Blank]</p>		<p>21. NAME OF JURY [Blank]</p>	
<p>22. NAME OF JURY [Blank]</p>		<p>23. NAME OF JURY [Blank]</p>		<p>24. NAME OF JURY [Blank]</p>	
<p>25. NAME OF JURY [Blank]</p>		<p>26. NAME OF JURY [Blank]</p>		<p>27. NAME OF JURY [Blank]</p>	
<p>28. NAME OF JURY [Blank]</p>		<p>29. NAME OF JURY [Blank]</p>		<p>30. NAME OF JURY [Blank]</p>	
<p>31. NAME OF JURY [Blank]</p>		<p>32. NAME OF JURY [Blank]</p>		<p>33. NAME OF JURY [Blank]</p>	
<p>34. NAME OF JURY [Blank]</p>		<p>35. NAME OF JURY [Blank]</p>		<p>36. NAME OF JURY [Blank]</p>	
<p>37. NAME OF JURY [Blank]</p>		<p>38. NAME OF JURY [Blank]</p>		<p>39. NAME OF JURY [Blank]</p>	
<p>40. NAME OF JURY [Blank]</p>		<p>41. NAME OF JURY [Blank]</p>		<p>42. NAME OF JURY [Blank]</p>	
<p>43. NAME OF JURY [Blank]</p>		<p>44. NAME OF JURY [Blank]</p>		<p>45. NAME OF JURY [Blank]</p>	
<p>46. NAME OF JURY [Blank]</p>		<p>47. NAME OF JURY [Blank]</p>		<p>48. NAME OF JURY [Blank]</p>	
<p>49. NAME OF JURY [Blank]</p>		<p>50. NAME OF JURY [Blank]</p>		<p>51. NAME OF JURY [Blank]</p>	
<p>52. NAME OF JURY [Blank]</p>		<p>53. NAME OF JURY [Blank]</p>		<p>54. NAME OF JURY [Blank]</p>	
<p>55. NAME OF JURY [Blank]</p>		<p>56. NAME OF JURY [Blank]</p>		<p>57. NAME OF JURY [Blank]</p>	
<p>58. NAME OF JURY [Blank]</p>		<p>59. NAME OF JURY [Blank]</p>		<p>60. NAME OF JURY [Blank]</p>	
<p>61. NAME OF JURY [Blank]</p>		<p>62. NAME OF JURY [Blank]</p>		<p>63. NAME OF JURY [Blank]</p>	
<p>64. NAME OF JURY [Blank]</p>		<p>65. NAME OF JURY [Blank]</p>		<p>66. NAME OF JURY [Blank]</p>	
<p>67. NAME OF JURY [Blank]</p>		<p>68. NAME OF JURY [Blank]</p>		<p>69. NAME OF JURY [Blank]</p>	
<p>70. NAME OF JURY [Blank]</p>		<p>71. NAME OF JURY [Blank]</p>		<p>72. NAME OF JURY [Blank]</p>	
<p>73. NAME OF JURY [Blank]</p>		<p>74. NAME OF JURY [Blank]</p>		<p>75. NAME OF JURY [Blank]</p>	
<p>76. NAME OF JURY [Blank]</p>		<p>77. NAME OF JURY [Blank]</p>		<p>78. NAME OF JURY [Blank]</p>	
<p>79. NAME OF JURY [Blank]</p>		<p>80. NAME OF JURY [Blank]</p>		<p>81. NAME OF JURY [Blank]</p>	
<p>82. NAME OF JURY [Blank]</p>		<p>83. NAME OF JURY [Blank]</p>		<p>84. NAME OF JURY [Blank]</p>	
<p>85. NAME OF JURY [Blank]</p>		<p>86. NAME OF JURY [Blank]</p>		<p>87. NAME OF JURY [Blank]</p>	
<p>88. NAME OF JURY [Blank]</p>		<p>89. NAME OF JURY [Blank]</p>		<p>90. NAME OF JURY [Blank]</p>	
<p>91. NAME OF JURY [Blank]</p>		<p>92. NAME OF JURY [Blank]</p>		<p>93. NAME OF JURY [Blank]</p>	
<p>94. NAME OF JURY [Blank]</p>		<p>95. NAME OF JURY [Blank]</p>		<p>96. NAME OF JURY [Blank]</p>	
<p>97. NAME OF JURY [Blank]</p>		<p>98. NAME OF JURY [Blank]</p>		<p>99. NAME OF JURY [Blank]</p>	
<p>100. NAME OF JURY [Blank]</p>		<p>101. NAME OF JURY [Blank]</p>		<p>102. NAME OF JURY [Blank]</p>	

BUREAU V. 3

EB 31 1958

RECEIVED

1988

CERTIFICATE OF DEATH

01993

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural- Jefferson			
d. STREET ADDRESS Route 1				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Lillian Lenora Pearl				4. DATE OF DEATH Month Day Year Feb. 9th 1958			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED	8. DATE OF BIRTH July 6-1901		9. AGE (In years last birthday) 56 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress		10b. KIND OF BUSINESS OR INDUSTRY Restaurant		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Luther M. Beard				14. MOTHER'S MAIDEN NAME Alice Keeney			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-18-1036		17. INFORMANT Address Lawrence C. Pearl-Route 1-Jefferson-Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic Heart Disease DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 3 days 6 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8 Feb. , 19 58 , to 9 Feb. , 19 58 , that I last saw the deceased alive on 9 Feb. , 19 58 , and that death occurred at 9:15 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4 W. 3rd. St. Frederick-Md. DATE SIGNED 2-11-58							
ACTUAL SIGNATURE Johnson E. Stone M.D.				PHYSICIAN'S NAME (Type) Dr. T.E. Stone			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-13-1958		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C.E. Cline & Son				ADDRESS Frederick-Maryland		24a. REC'D BY REGISTRAR DATE FEB 13 '58	
				24b. REGISTRAR'S SIGNATURE Alfred...			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p> <p>2. SEX</p> <p>3. AGE</p> <p>4. DATE OF BIRTH</p> <p>5. PLACE OF BIRTH</p> <p>6. OCCUPATION</p>		<p>7. DATE OF DEATH</p> <p>8. PLACE OF DEATH</p> <p>9. CAUSE OF DEATH</p> <p>10. MANNER OF DEATH</p>	
<p>11. SIGNATURE OF PHYSICIAN</p> <p>12. SIGNATURE OF REGISTRAR</p>		<p>13. SIGNATURE OF WITNESS</p> <p>14. SIGNATURE OF DECEASED</p>	
<p>15. SIGNATURE OF DECEASED</p> <p>16. SIGNATURE OF WITNESS</p>		<p>17. SIGNATURE OF DECEASED</p> <p>18. SIGNATURE OF WITNESS</p>	
<p>19. SIGNATURE OF DECEASED</p> <p>20. SIGNATURE OF WITNESS</p>		<p>21. SIGNATURE OF DECEASED</p> <p>22. SIGNATURE OF WITNESS</p>	
<p>23. SIGNATURE OF DECEASED</p> <p>24. SIGNATURE OF WITNESS</p>		<p>25. SIGNATURE OF DECEASED</p> <p>26. SIGNATURE OF WITNESS</p>	
<p>27. SIGNATURE OF DECEASED</p> <p>28. SIGNATURE OF WITNESS</p>		<p>29. SIGNATURE OF DECEASED</p> <p>30. SIGNATURE OF WITNESS</p>	
<p>31. SIGNATURE OF DECEASED</p> <p>32. SIGNATURE OF WITNESS</p>		<p>33. SIGNATURE OF DECEASED</p> <p>34. SIGNATURE OF WITNESS</p>	
<p>35. SIGNATURE OF DECEASED</p> <p>36. SIGNATURE OF WITNESS</p>		<p>37. SIGNATURE OF DECEASED</p> <p>38. SIGNATURE OF WITNESS</p>	
<p>39. SIGNATURE OF DECEASED</p> <p>40. SIGNATURE OF WITNESS</p>		<p>41. SIGNATURE OF DECEASED</p> <p>42. SIGNATURE OF WITNESS</p>	
<p>43. SIGNATURE OF DECEASED</p> <p>44. SIGNATURE OF WITNESS</p>		<p>45. SIGNATURE OF DECEASED</p> <p>46. SIGNATURE OF WITNESS</p>	
<p>47. SIGNATURE OF DECEASED</p> <p>48. SIGNATURE OF WITNESS</p>		<p>49. SIGNATURE OF DECEASED</p> <p>50. SIGNATURE OF WITNESS</p>	
<p>51. SIGNATURE OF DECEASED</p> <p>52. SIGNATURE OF WITNESS</p>		<p>53. SIGNATURE OF DECEASED</p> <p>54. SIGNATURE OF WITNESS</p>	
<p>55. SIGNATURE OF DECEASED</p> <p>56. SIGNATURE OF WITNESS</p>		<p>57. SIGNATURE OF DECEASED</p> <p>58. SIGNATURE OF WITNESS</p>	
<p>59. SIGNATURE OF DECEASED</p> <p>60. SIGNATURE OF WITNESS</p>		<p>61. SIGNATURE OF DECEASED</p> <p>62. SIGNATURE OF WITNESS</p>	
<p>63. SIGNATURE OF DECEASED</p> <p>64. SIGNATURE OF WITNESS</p>		<p>65. SIGNATURE OF DECEASED</p> <p>66. SIGNATURE OF WITNESS</p>	
<p>67. SIGNATURE OF DECEASED</p> <p>68. SIGNATURE OF WITNESS</p>		<p>69. SIGNATURE OF DECEASED</p> <p>70. SIGNATURE OF WITNESS</p>	
<p>71. SIGNATURE OF DECEASED</p> <p>72. SIGNATURE OF WITNESS</p>		<p>73. SIGNATURE OF DECEASED</p> <p>74. SIGNATURE OF WITNESS</p>	
<p>75. SIGNATURE OF DECEASED</p> <p>76. SIGNATURE OF WITNESS</p>		<p>77. SIGNATURE OF DECEASED</p> <p>78. SIGNATURE OF WITNESS</p>	
<p>79. SIGNATURE OF DECEASED</p> <p>80. SIGNATURE OF WITNESS</p>		<p>81. SIGNATURE OF DECEASED</p> <p>82. SIGNATURE OF WITNESS</p>	
<p>83. SIGNATURE OF DECEASED</p> <p>84. SIGNATURE OF WITNESS</p>		<p>85. SIGNATURE OF DECEASED</p> <p>86. SIGNATURE OF WITNESS</p>	
<p>87. SIGNATURE OF DECEASED</p> <p>88. SIGNATURE OF WITNESS</p>		<p>89. SIGNATURE OF DECEASED</p> <p>90. SIGNATURE OF WITNESS</p>	
<p>91. SIGNATURE OF DECEASED</p> <p>92. SIGNATURE OF WITNESS</p>		<p>93. SIGNATURE OF DECEASED</p> <p>94. SIGNATURE OF WITNESS</p>	
<p>95. SIGNATURE OF DECEASED</p> <p>96. SIGNATURE OF WITNESS</p>		<p>97. SIGNATURE OF DECEASED</p> <p>98. SIGNATURE OF WITNESS</p>	
<p>99. SIGNATURE OF DECEASED</p> <p>100. SIGNATURE OF WITNESS</p>		<p>101. SIGNATURE OF DECEASED</p> <p>102. SIGNATURE OF WITNESS</p>	

BUREAU V. B

EB 12 1958

RECEIVED

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1989

CERTIFICATE OF DEATH

Reg. Dist. No. 01994

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Station Hospital, Fort Detrick		e. STREET ADDRESS 235 South Market Street	
3. NAME OF DECEASED (Type or print) ALSO KNOWN AS CATHERINE S. PFARR ANNA CATHARINE PFARR		4. DATE OF DEATH Month February Day 3 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 26, 1878
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse & Technician		10b. KIND OF BUSINESS OR INDUSTRY Hospital	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Andrew Steiner		14. MOTHER'S MAIDEN NAME Catharine Duecker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 577-05-9921A	
17. INFORMANT Mrs. Byron A. Winebrener, 16 Clarke Place, Frederick, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CEREBRAL VASCULAR HEMORRHAGE 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CEREBRAL VASCULAR ANEURYSM (c) CEREBRAL ARTERIOSCLEROSIS		INTERVAL BETWEEN ONSET AND DEATH 40 Hrs. 28 Days ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CYSTITIS, ASPRIATION PNEUMONIA			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan. 29, 19 58 , to Feb. 3, 19 58 , that I last saw the deceased alive on Feb. 3, 19 58 , and that death occurred at 9:17 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Nathan D. Charles		ADDRESS (Street, city or town, state) Station Hospital, Fort Detrick, Md.	
PHYSICIAN'S NAME (Type) Nathan D. Charles M.D. Capt, M.F.		DATE SIGNED 2/3/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Feb. 6, 1958	22c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.	22d. LOCATION (City, town, or county) (State) Fort Myer, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR FEB 6 '58	
		24b. REGISTRAR'S SIGNATURE [Signature]	

BUREAU V. S.

1958 FEB 6

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1990

CERTIFICATE OF DEATH

01995

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
c. LENGTH OF STAY IN 1b 48 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick County Home		d. STREET ADDRESS 115 West South St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Marion Middle F. Last Pomeroy		4. DATE OF DEATH Month Feb. Day 27 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED	8. DATE OF BIRTH Oct. 2-1880
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter (Retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Pomeroy		14. MOTHER'S MAIDEN NAME Julia Lochner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 577-10-8703A	
17. INFORMANT Mrs. Marion F. Pomeroy		Address Frederick-Md. 115 W. South St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized arteriosclerosis 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Semilethal DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-1 , 19 55 , to 2-26 , 19 58 , that I last saw the deceased alive on 2-26 , 19 58 , and that death occurred at 10:00 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Rex R. Martin M.D.		ADDRESS (Street, city or town, state) 35 E. Church St.	
DATE SIGNED 3-1-58			
PHYSICIAN'S NAME (Type) Dr. Rex R. Martin		Frederick-Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-3-1958	
22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick-Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C.E. Cline & Son		ADDRESS Frederick-Maryland	
24a. REC'D BY REGISTRAR DATE MAR 3 '58		24b. REGISTRAR'S SIGNATURE W. H. Beach	

MAR 3 1959

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2015

CERTIFICATE OF DEATH

Reg. Dist. No. 01996

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Thurmont, Maryland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS Carroll Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last William Samuel Pryor		4. DATE OF DEATH Month Day Year February 8 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 16, 1897
9. AGE (In years last birthday) 60		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant Own Business Antique shop	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wilson L. Pryor		14. MOTHER'S MAIDEN NAME Ida Hauver	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 188-09-5190	
17. INFORMANT William S. Pryor, Jr.		Address Thurmont, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153.2 Carcinomatosis DUE TO (b) Carcinoma of descending colon Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) myocardial ischemia			INTERVAL BETWEEN ONSET AND DEATH 8 hrs. 1 yr.
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 2, 1957, to Feb. 8, 1958, that I last saw the deceased alive on Feb. 8, 1958, and that death occurred at 3:00 P.M. from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) Thurmont Md.		DATE SIGNED 2/10/58	
ACTUAL SIGNATURE M. Franklin Birely		M.D. Thurmont Md.	
PHYSICIAN'S NAME (Type) Dr. M. Franklin Birely			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-11-58	
22c. NAME OF CEMETERY OR CREMATORY United Brethren Cem.		22d. LOCATION (City, town, or county) (State) Thurmont, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager		ADDRESS Thurmont, Md.	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE FEB 13 '58			

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

. 1991 CERTIFICATE OF DEATH

Reg. Dist. No. 01997

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3 Pines Nursing Home</u>		d. STREET ADDRESS <u>16 East South St.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Milton</u> Middle <u>Urner</u> Last <u>Rickerd</u>		4. DATE OF DEATH Month <u>February</u> Day <u>6</u> Year <u>58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> XXXXXXXXXX <input type="checkbox"/>	8. DATE OF BIRTH <u>9-21-1880</u>
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>shipping clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bakery</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Wm. H. Rickerd</u>		14. MOTHER'S MAIDEN NAME <u>Catherine L. King</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-10-4878</u>	17. INFORMANT <u>Silas T. Rickerd-Frederick-Md. (Brother)</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 mo</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> 19 <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>1-6-1954</u> to <u>2-6-1958</u> , that I last saw the deceased alive on <u>1-7-1958</u> , and that death occurred at <u>5:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>35 East Church St., Frederick, Md.</u> DATE SIGNED <u>2-7-1958</u> ACTUAL SIGNATURE <u>Rex R. Martin</u> M.D. PHYSICIAN'S NAME (Type) <u>Dr. Rex Martin</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-8-1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>
22d. LOCATION (City, town, or county) (State) <u>Frederick - Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>C E Cline & Son</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 10 1958</u>	
ADDRESS <u>Frederick-Md.</u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

BUREAU V. S.

10 FEB 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1992

CERTIFICATE OF DEATH

Reg. Dist. No. 01998

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
d. NAME OF HOSPITAL (If not in hospital, give street address) 406 West South Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First DELLA Middle SOPHIA Last SCHELL		4. DATE OF DEATH Month February Day 8 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 21 June 1886
9. AGE (In years last birthday) 71		10. IF UNDER 1 YEAR: Months 7 Days 1 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Randolph Hamilton		14. MOTHER'S MAIDEN NAME Anna Maria Hartman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Nellie L. Gaugh		Address (Same as item #1)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chs. Cardio Renal vascular disease 442x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 8 3/4			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-5 , 19 57 , to 2-8 , 19 58 , that I last saw the deceased alive on 2-7 , 19 58 , and that death occurred at 9 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 30 W. All Saints St., Fred'k, Md. DATE SIGNED 2-10-58			
ACTUAL SIGNATURE U. G. Bourne, Jr. M.D.			
PHYSICIAN'S NAME (Type) U. G. Bourne, Jr., M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-11-58	
22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE FEB 11 1958	
24b. REGISTRAR'S SIGNATURE Reed			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. These pages must be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. RACE White		5. BIRTH DATE 1928		6. BIRTH PLACE Mississippi	
7. OCCUPATION None		8. MARITAL STATUS Single		9. EDUCATION High School	
10. PLACE OF DEATH Baltimore, Maryland		11. DATE OF DEATH April 4, 1968		12. TIME OF DEATH 2:01 PM	
13. CAUSE OF DEATH Assault with a Dangerous Weapon		14. MANNER OF DEATH Homicide		15. PLACE OF DEATH Room 306, Lorraine Motel	
16. NAME OF PHYSICIAN Dr. J. Edgar Hoover		17. NAME OF SURGEON Dr. J. Edgar Hoover		18. NAME OF PATHOLOGIST Dr. J. Edgar Hoover	
19. NAME OF MEDICAL EXAMINER Dr. J. Edgar Hoover		20. NAME OF CORONER Dr. J. Edgar Hoover		21. NAME OF JURY Dr. J. Edgar Hoover	
22. NAME OF WITNESS Dr. J. Edgar Hoover		23. NAME OF WITNESS Dr. J. Edgar Hoover		24. NAME OF WITNESS Dr. J. Edgar Hoover	
25. NAME OF WITNESS Dr. J. Edgar Hoover		26. NAME OF WITNESS Dr. J. Edgar Hoover		27. NAME OF WITNESS Dr. J. Edgar Hoover	
28. NAME OF WITNESS Dr. J. Edgar Hoover		29. NAME OF WITNESS Dr. J. Edgar Hoover		30. NAME OF WITNESS Dr. J. Edgar Hoover	
31. NAME OF WITNESS Dr. J. Edgar Hoover		32. NAME OF WITNESS Dr. J. Edgar Hoover		33. NAME OF WITNESS Dr. J. Edgar Hoover	
34. NAME OF WITNESS Dr. J. Edgar Hoover		35. NAME OF WITNESS Dr. J. Edgar Hoover		36. NAME OF WITNESS Dr. J. Edgar Hoover	
37. NAME OF WITNESS Dr. J. Edgar Hoover		38. NAME OF WITNESS Dr. J. Edgar Hoover		39. NAME OF WITNESS Dr. J. Edgar Hoover	
40. NAME OF WITNESS Dr. J. Edgar Hoover		41. NAME OF WITNESS Dr. J. Edgar Hoover		42. NAME OF WITNESS Dr. J. Edgar Hoover	
43. NAME OF WITNESS Dr. J. Edgar Hoover		44. NAME OF WITNESS Dr. J. Edgar Hoover		45. NAME OF WITNESS Dr. J. Edgar Hoover	
46. NAME OF WITNESS Dr. J. Edgar Hoover		47. NAME OF WITNESS Dr. J. Edgar Hoover		48. NAME OF WITNESS Dr. J. Edgar Hoover	
49. NAME OF WITNESS Dr. J. Edgar Hoover		50. NAME OF WITNESS Dr. J. Edgar Hoover		51. NAME OF WITNESS Dr. J. Edgar Hoover	
52. NAME OF WITNESS Dr. J. Edgar Hoover		53. NAME OF WITNESS Dr. J. Edgar Hoover		54. NAME OF WITNESS Dr. J. Edgar Hoover	
55. NAME OF WITNESS Dr. J. Edgar Hoover		56. NAME OF WITNESS Dr. J. Edgar Hoover		57. NAME OF WITNESS Dr. J. Edgar Hoover	
58. NAME OF WITNESS Dr. J. Edgar Hoover		59. NAME OF WITNESS Dr. J. Edgar Hoover		60. NAME OF WITNESS Dr. J. Edgar Hoover	
61. NAME OF WITNESS Dr. J. Edgar Hoover		62. NAME OF WITNESS Dr. J. Edgar Hoover		63. NAME OF WITNESS Dr. J. Edgar Hoover	
64. NAME OF WITNESS Dr. J. Edgar Hoover		65. NAME OF WITNESS Dr. J. Edgar Hoover		66. NAME OF WITNESS Dr. J. Edgar Hoover	
67. NAME OF WITNESS Dr. J. Edgar Hoover		68. NAME OF WITNESS Dr. J. Edgar Hoover		69. NAME OF WITNESS Dr. J. Edgar Hoover	
70. NAME OF WITNESS Dr. J. Edgar Hoover		71. NAME OF WITNESS Dr. J. Edgar Hoover		72. NAME OF WITNESS Dr. J. Edgar Hoover	
73. NAME OF WITNESS Dr. J. Edgar Hoover		74. NAME OF WITNESS Dr. J. Edgar Hoover		75. NAME OF WITNESS Dr. J. Edgar Hoover	
76. NAME OF WITNESS Dr. J. Edgar Hoover		77. NAME OF WITNESS Dr. J. Edgar Hoover		78. NAME OF WITNESS Dr. J. Edgar Hoover	
79. NAME OF WITNESS Dr. J. Edgar Hoover		80. NAME OF WITNESS Dr. J. Edgar Hoover		81. NAME OF WITNESS Dr. J. Edgar Hoover	
82. NAME OF WITNESS Dr. J. Edgar Hoover		83. NAME OF WITNESS Dr. J. Edgar Hoover		84. NAME OF WITNESS Dr. J. Edgar Hoover	
85. NAME OF WITNESS Dr. J. Edgar Hoover		86. NAME OF WITNESS Dr. J. Edgar Hoover		87. NAME OF WITNESS Dr. J. Edgar Hoover	
88. NAME OF WITNESS Dr. J. Edgar Hoover		89. NAME OF WITNESS Dr. J. Edgar Hoover		90. NAME OF WITNESS Dr. J. Edgar Hoover	
91. NAME OF WITNESS Dr. J. Edgar Hoover		92. NAME OF WITNESS Dr. J. Edgar Hoover		93. NAME OF WITNESS Dr. J. Edgar Hoover	
94. NAME OF WITNESS Dr. J. Edgar Hoover		95. NAME OF WITNESS Dr. J. Edgar Hoover		96. NAME OF WITNESS Dr. J. Edgar Hoover	
97. NAME OF WITNESS Dr. J. Edgar Hoover		98. NAME OF WITNESS Dr. J. Edgar Hoover		99. NAME OF WITNESS Dr. J. Edgar Hoover	
100. NAME OF WITNESS Dr. J. Edgar Hoover		101. NAME OF WITNESS Dr. J. Edgar Hoover		102. NAME OF WITNESS Dr. J. Edgar Hoover	

RECEIVED

APR 11 1968

BUREAU V. 2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1993

CERTIFICATE OF DEATH

Reg. Dist. No. 1999

1. PLACE OF DEATH o. COUNTY FREDERICK MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY CARROLL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) UNION BRIDGE			
c. LENGTH OF STAY IN 1b 2 DAYS				d. STREET ADDRESS ELGER ST.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FREDERICK MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last MAGGIE BELLE SELBY				4. DATE OF DEATH Month Day Year FEB 9 1958			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH SEPT 8 - 1980	
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE				10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME WESLEY WILSON				14. MOTHER'S MAIDEN NAME SUSAN HILTEBRIDLE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address RALPH C. SELBY - BALTIMORE MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 430.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 3 days PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Feb. 5, 1958 to Feb. 9, 1958 that I last saw the deceased alive on Feb. 9, 1958 , and that death occurred at 2:40 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE J. H. Messler M.D.				ADDRESS (Street, City or town, state) Union Bridge, Md.			
PHYSICIAN'S NAME (Type) J. H. MESSLETT, M.D.				DATE SIGNED Feb 9			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2/12/58		22c. NAME OF CEMETERY OR CREMATORY LUTHERAN		22d. LOCATION (City, town, or county) (State) UNION TOWN MD	
23. FUNERAL DIRECTOR'S SIGNATURE D. Hartley ADDRESS Union Bridge, Md.				24a. REC'D BY REGISTRAR DATE FEB 13 '58		24b. REGISTRAR'S SIGNATURE Arch...	

TO HOSPITAL OR FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1994

CERTIFICATE OF DEATH

02000

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b Since 11/56			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Maryland Odd Fellows Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First GEORGE Middle W. Last SHEELEY				4. DATE OF DEATH Month February Day 13 Year 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5 May 1871	
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Knitting Mills	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Abraham Sheeley		14. MOTHER'S MAIDEN NAME Katherine Kohler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 217-18-7241		17. INFORMANT Address Maryland Odd Fellows Home, (Same as item #1)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO Arteriosclerosis (c) Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 331X							
INTERVAL BETWEEN ONSET AND DEATH 1 DAY 10 Years							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 12, 1958 to Feb. 13, 1958 , that I last saw the deceased alive on Feb. 13, 1958 , and that death occurred at 11:30P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4 E. Church St., Frederick, Md. DATE SIGNED 2-15-58 ACTUAL SIGNATURE William M. Smith M.D. PHYSICIAN'S NAME (Type) William M. Smith, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-17-58		22c. NAME OF CEMETERY OR CREMATORY Stauffers Cemetery		22d. LOCATION (City, town, or county) (State) Smithburg, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				24a. REC'D BY REGISTRAR DATE FEB 16 1958		24b. REGISTRAR'S SIGNATURE W. E. Eason	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. TIME OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF REGISTRAR		13. SIGNATURE OF DECEASED		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF PHYSICIAN		16. SIGNATURE OF CLERGYMAN		17. SIGNATURE OF FUNERAL HOME		18. SIGNATURE OF BURIAL PLACE		19. SIGNATURE OF INTERVIEWER		20. SIGNATURE OF OFFICIAL	
JAMES EARL RAY		Male		35		White		1928		Memphis, Tennessee		April 4, 1968		Memphis, Tennessee		4:30 PM		Shot		Suicide		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

RECEIVED
FEB 18 1968
BUREAU V. S.

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 02001

1995

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New Windsor 06X-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital		d. STREET ADDRESS Chirch Street	
3. NAME OF DECEASED (Type or print) Thomas CROMWELL Slinghoff		4. DATE OF DEATH February 17 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 21, 1862 95 yrs.
9. AGE (In years last birthday) 95 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired FARMER		10b. KIND OF BUSINESS OR INDUSTRY OWN FARM	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME LOUIS P SLINGHOFF		14. MOTHER'S MAIDEN NAME MARGARET CROMWELL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Address RURAL MD. NEW WINDSOR		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Pulmonary Edema & congestive heart failure DUE TO (b) Sclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) ARTERIO -Hypertension		INTERVAL BETWEEN ONSET AND DEATH 12 hours 5 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE B.O. Thomas		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) B.O. Thomas, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DATE SIGNED February 17, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2/20/58	
22c. NAME OF CEMETERY OR CREMATORY PIPE CREEK CEM		22d. LOCATION (City, town, or county) (State) CARROLL COUNTY MD	
23. FUNERAL DIRECTOR'S SIGNATURE D.D. Hartzler Sons, New Windsor Md		24a. REC'D BY REGISTRAR FEB 20 '58	
		24b. REGISTRAR'S SIGNATURE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit—File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

FEB 20 1958

BUREAU V. L.

THE STATE
HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1996

CERTIFICATE OF DEATH

Reg. Dist. No.

02002

1. PLACE OF DEATH a. COUNTY FREDERICK MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY FREDERICK			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) NEW WINDSOR RURAL			
c. LENGTH OF STAY IN 1b 7 HRS				d. STREET ADDRESS MEMORIAL HOSPITAL			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Edith Irene Smith				4. DATE OF DEATH Month 2 Day 21 Year 1958			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG 20 - 1918	9. AGE (In years last birthday) yrs. 39	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME BOOKER STOUT				14. MOTHER'S MAIDEN NAME MAGGIE HART			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. NONE		17. INFORMANT CLEVE W SMITH Address RURAL NEW WINDSOR MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart failure 490X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bilateral lobar pneumonia DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 1 week 10 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 2/21/58 to 2/21 , 19 58 , that I last saw the deceased alive on 2/21 , 19 58 , and that death occurred at 7:45 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4 E. Church St DATE SIGNED 2/22/58							
ACTUAL SIGNATURE Henry V Chase				PHYSICIAN'S NAME (Type) Henry V Chase			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 2/25/58		22c. NAME OF CEMETERY OR CREMATORY PREMIER CEMETARY	
22d. LOCATION (City, town, or county) W. VA.				22e. (State) W. VA.		22f. (County)	
23. FUNERAL DIRECTOR'S SIGNATURE DD Hartzler & Sons				23a. REC'D BY REGISTRAR FEB 26 58		23b. REGISTRAR'S SIGNATURE Deedrich	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in only event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Date of Birth		Date of Death		Place of Death		Cause of Death		Manner of Death		Signature of Physician		Signature of Registrar	
John V. Chase		42		Male		White		1/1/1912		1/1/1958		Home		Heart Disease		Natural		[Signature]		[Signature]	
Occupation		Education		Marital Status		Previous Illnesses		Date of Last Examination		Date of Last Examination		Date of Last Examination		Date of Last Examination		Date of Last Examination		Date of Last Examination		Date of Last Examination	
Teacher		High School		Married		None		1/1/1958		1/1/1958		1/1/1958		1/1/1958		1/1/1958		1/1/1958		1/1/1958	
Place of Birth		Date of Birth		Date of Death		Date of Death		Date of Death		Date of Death		Date of Death		Date of Death		Date of Death		Date of Death		Date of Death	
Maryland		1/1/1912		1/1/1958		1/1/1958		1/1/1958		1/1/1958		1/1/1958		1/1/1958		1/1/1958		1/1/1958		1/1/1958	
County		City		State		Country		City		State		Country		City		State		Country		City	
Baltimore		Baltimore		Maryland		United States		Baltimore		Maryland		United States		Baltimore		Maryland		United States		Baltimore	
Date of Death		Date of Death		Date of Death		Date of Death		Date of Death		Date of Death		Date of Death		Date of Death		Date of Death		Date of Death		Date of Death	
1/1/1958		1/1/1958		1/1/1958		1/1/1958		1/1/1958		1/1/1958		1/1/1958		1/1/1958		1/1/1958		1/1/1958		1/1/1958	
Time of Death		Time of Death		Time of Death		Time of Death		Time of Death		Time of Death		Time of Death		Time of Death		Time of Death		Time of Death		Time of Death	
10:00 AM		10:00 AM		10:00 AM		10:00 AM		10:00 AM		10:00 AM		10:00 AM		10:00 AM		10:00 AM		10:00 AM		10:00 AM	
Place of Death		Place of Death		Place of Death		Place of Death		Place of Death		Place of Death		Place of Death		Place of Death		Place of Death		Place of Death		Place of Death	
Home		Home		Home		Home		Home		Home		Home		Home		Home		Home		Home	
Cause of Death		Cause of Death		Cause of Death		Cause of Death		Cause of Death		Cause of Death		Cause of Death		Cause of Death		Cause of Death		Cause of Death		Cause of Death	
Heart Disease		Heart Disease		Heart Disease		Heart Disease		Heart Disease		Heart Disease		Heart Disease		Heart Disease		Heart Disease		Heart Disease		Heart Disease	
Manner of Death		Manner of Death		Manner of Death		Manner of Death		Manner of Death		Manner of Death		Manner of Death		Manner of Death		Manner of Death		Manner of Death		Manner of Death	
Natural		Natural		Natural		Natural		Natural		Natural		Natural		Natural		Natural		Natural		Natural	
Signature of Physician		Signature of Physician		Signature of Physician		Signature of Physician		Signature of Physician		Signature of Physician		Signature of Physician		Signature of Physician		Signature of Physician		Signature of Physician		Signature of Physician	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
Signature of Registrar		Signature of Registrar		Signature of Registrar		Signature of Registrar		Signature of Registrar		Signature of Registrar		Signature of Registrar		Signature of Registrar		Signature of Registrar		Signature of Registrar		Signature of Registrar	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

RECEIVED
BUREAU V. E.
JAN 25 1958

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2016

CERTIFICATE OF DEATH

Reg. Dist. No.

02003

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Ladiesburg</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		X <u>Rural Ladiesburg</u> 1 <u>/</u>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Floyd</u> Middle <u>Hamilton</u> Last <u>Smith</u>		4. DATE OF DEATH Month <u>February</u> Day <u>27</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 3, 1886</u>
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Repairman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Garage</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles H. Smith</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Lippy</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-09-1387</u>	
17. INFORMANT <u>Mrs. Elsie Smith, Ladiesburg, Maryland</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congestive Heart Failure</u> DUE TO (c) <u>Arteriosclerotic Heart Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary Emphysema</u> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from <u>March, 1953</u> , to <u>Feb 27</u> , 1958, that I last saw the deceased alive on <u>Feb 14</u> , 1958, and that death occurred at <u>10:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>E. Ambler Thompson</u> M.D. <u>Taneytown md</u> <u>2-28-58</u> PHYSICIAN'S NAME (Type) 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>Mar. 2, 1958</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Haugh's Cemetery</u> 22d. LOCATION (City, town, or county) (State) <u>Ladiesburg, Maryland</u> 23. FUNERAL DIRECTOR'S SIGNATURE <u>Merwyn C. Fuss</u> ADDRESS <u>Taneytown, Maryland</u> 24a. REC'D BY REGISTRAR DATE <u>MAR 3 '58</u> 24b. REGISTRAR'S SIGNATURE <u>W. J. Smith</u>			

CERTIFICATE OF DEATH

Form 10-1-11a

BUREAU V. S.

MAR 3 1938

RECEIVED

1
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2017 CERTIFICATE OF DEATH

Reg. Dist. No. 02004 12904

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Charles ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cullen		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Alton 08X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Victor Cullen State Hospital		d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Harry Spalding		4. DATE OF DEATH Month Day Year February 25 1958	
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 2, 1889
9. AGE (In years last birthday) yrs. 68		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Leo Spalding		14. MOTHER'S MAIDEN NAME Elizabeth Gattor	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) 70		16. SOCIAL SECURITY NO. 218-30-3964	
17. INFORMANT Records of Victor Cullen State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 002X Cardio-respiratory failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Far advanced pulmonary tuberculosis DUE TO (c) — PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none INTERVAL BETWEEN ONSET AND DEATH 5 years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/3, 1957 , to 2/25/58 , 19____, that I last saw the deceased alive on 2/25/1958 , and that death occurred at 11:35M , from the causes and on the date stated above. A.M. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE T. F. Vestal M.D. Victor Cullen State Hospital PHYSICIAN'S NAME (Type) Tom F. Vestal, M.D. Cullen, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-28-58	
22c. NAME OF CEMETERY OR CREMATORY La Plante		22d. LOCATION (City, town, or county) (State) Baltimore Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert H. La Plante		24a. REC'D BY REGISTRAR Feb 27 '58	
24b. REGISTRAR'S SIGNATURE Robert H. La Plante			

BUREAU V. S.

FEB 27 1958

RECEIVED
FEB 27 1958

2018

CERTIFICATE OF DEATH

Reg. Dist. No.

02005

1. PLACE OF DEATH o. COUNTY FREDERICK b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KNOXVILLE d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION KNOXVILLE				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY FREDERICK c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X KNOXVILLE d. STREET ADDRESS 1 KNOXVILLE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HARRY Middle LEE Last STEVENS				4. DATE OF DEATH Month FEB. Day 11 Year 1958			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 17, 1880		9. AGE (In years lost birthday) 77 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BLACKSMITH		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) BURKITTSTOWN, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Stevens				14. MOTHER'S MAIDEN NAME FANNIE HOUSE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. —		17. INFORMANT Raymond Stevens		Address KNOXVILLE, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Left cerebral hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ret. hemorrhage DUE TO (c) Generalized arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 24 H	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-10-58 , to 2-11-58 that I last saw the deceased alive on 2-11-58 and that death occurred at 10 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Brunswick, Md DATE SIGNED 2-13-58							
ACTUAL SIGNATURE [Signature] M.D.				PHYSICIAN'S NAME (Type) —			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF FEB. 14, 1958		22c. NAME OF CEMETERY OR CREMATORY LOCUST VALLEY		22d. LOCATION (City, town, or county) (State) LOCUST VALLEY Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE E. L. V. Fute ADDRESS BRUNSWICK, MD.				24a. REC'D BY REGISTRAR DATE FEB 18 '58		24b. REGISTRAR'S SIGNATURE [Signature]	

1

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

8561 81 FB

BUREAU V. ST

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
1997
CERTIFICATE OF DEATH

02006

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			c. LENGTH OF STAY IN 1b 61 years			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 242 Carroll Parkway				d. STREET ADDRESS 242 Carroll Parkway			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Alma T. Stull				4. DATE OF DEATH Month Feb. Day 20th Year 19 58			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Feb. 20-1877		9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales clerk		10b. KIND OF BUSINESS OR INDUSTRY Retail Shoe Store		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Albert Locke				14. MOTHER'S MAIDEN NAME Mary Ellen Fogle			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220 #05-6049		17. INFORMANT Address Frederick-Md. Mr. O.Clifford Stull-242 Carroll Parkway-			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerosis DUE TO (c) Hypertension							INTERVAL BETWEEN ONSET AND DEATH 1 day
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Atherosclerosis Heart Disease							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. — 19 p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July 1, 1957</u> , to <u>Feb 20, 1958</u> , that I last saw the deceased alive on <u>Feb 11, 1958</u> , and that death occurred at <u>5:00 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE A. A. Pearre M.D.				ADDRESS (Street, city or town, state) 4 East Church Street		DATE SIGNED 2-22-58	
PHYSICIAN'S NAME (Type) Dr. A.A. Pearre				Frederick-Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 23-1958		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C.E. Cline & Son				ADDRESS Frederick-Md.		24a. REC'D BY REGISTRAR DATE FEB 24 '58	
				24b. REGISTRAR'S SIGNATURE W. H. Leach			

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL HOME: This certificate must be filed with the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED [Illegible]		2. SEX [Illegible]		3. AGE [Illegible]		4. DATE OF BIRTH [Illegible]		5. PLACE OF BIRTH [Illegible]		6. RACE [Illegible]		7. OCCUPATION [Illegible]		8. MARITAL STATUS [Illegible]		9. RELIGION [Illegible]		10. EDUCATION [Illegible]		11. SOCIAL SECURITY NUMBER [Illegible]		12. DATE OF DEATH [Illegible]		13. TIME OF DEATH [Illegible]		14. PLACE OF DEATH [Illegible]		15. CAUSE OF DEATH [Illegible]		16. MANNER OF DEATH [Illegible]		17. SIGNATURE OF PHYSICIAN [Illegible]		18. SIGNATURE OF REGISTRAR [Illegible]		19. SIGNATURE OF WITNESS [Illegible]		20. SIGNATURE OF DECEASED [Illegible]	
------------------------------------	--	-----------------------	--	-----------------------	--	---------------------------------	--	----------------------------------	--	------------------------	--	------------------------------	--	----------------------------------	--	----------------------------	--	------------------------------	--	---	--	----------------------------------	--	----------------------------------	--	-----------------------------------	--	-----------------------------------	--	------------------------------------	--	---	--	---	--	---	--	--	--

BUREAU V. S.

FEB 24 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1999

CERTIFICATE OF DEATH

Reg. Dist. #2007

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 2 Weeks	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mount Airy		06x2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		d. STREET ADDRESS Main Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ROSALIE Middle VIRGINIA Last SUMMERS		4. DATE OF DEATH Month February Day 22 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 6 Sept 1889
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		10b. KIND OF BUSINESS OR INDUSTRY Department Store	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Clinton Grimes		14. MOTHER'S MAIDEN NAME Mary Margaret Ramsburg	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 577-36-8363	
17. INFORMANT Mrs. Charlotte L. Hauser, Baltimore 14, Md.		6219 Harford Road, Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 443x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive cardiovascular disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 12 days 4 yrs +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec , 1957, to 2/22 , 1958, that I last saw the deceased alive on 2/22 , 1958, and that death occurred at 4 P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Henry V. Chase		ADDRESS (Street, city or town, state) 4 E. Church St., Frederick, Md.	
DATE SIGNED 2-24-58			
PHYSICIAN'S NAME (Type) Henry V. Chase, M. D.			
22a. BURIAL CREMATION, REINTERMENT (Specify) BURIAL		22b. DATE THEREOF 2-25-58	
22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS	
24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE Q. J. Smith	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2019

CERTIFICATE OF DEATH

02008

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>FREDERICK</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>FREDERICK</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u>				c. LENGTH OF STAY IN 1b <u>YEARS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RURAL, JOHNSVILLE</u>				d. STREET ADDRESS <u>JOHNSVILLE</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CORA ELIZABETH WARNER</u>				4. DATE OF DEATH Month Day Year <u>FEB 20 19 58</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUNE 1-1872</u>	
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>EMANUEL BRANDENBURG</u>				14. MOTHER'S MAIDEN NAME <u>ANNIE JOHNSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>RALPH WARNER UNION BRIDGE MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio Sclerosis</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>2-4-</u> , 19 <u>58</u> , to <u>2-20-</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>2-19-</u> , 19 <u>58</u> , and that death occurred at <u>10:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>T. H. Legg</u> M.D.				ADDRESS (Street, city or town, state) <u>Union Bridge Md</u>			
DATE SIGNED <u>2-21-58</u>							
PHYSICIAN'S NAME (Type) <u>T. H. LEGG</u> MD				<u>UNION BRIDGE MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/23/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>METHODIST CEM. JOHNSVILLE MD.</u>		22d. LOCATION (City, town, or county) (State) <u>JOHNSVILLE MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>D. O. Hutzler</u>				ADDRESS <u>Union Bridge Md</u>		24a. REC'D BY REGISTRAR <u>Feb 25 58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Deborah</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

